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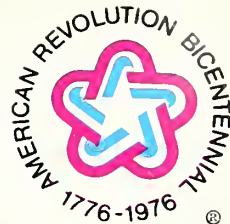




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# [MJ] *Illinois Medical Journal*



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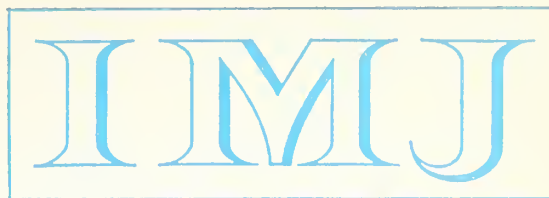
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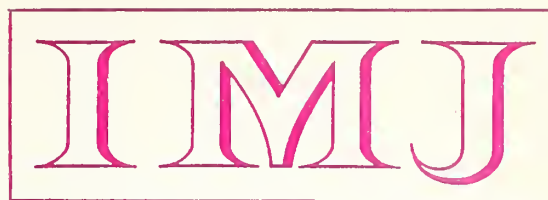
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# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

### DISALLOWED INPATIENT STAYS UNDER BLUE CROSS

On occasion Blue Cross subscribers are faced with the personal obligation to pay substantial sums for hospital expenses which they had assumed would be covered by their Blue Cross certificate. Most physicians wish to protect their patients from such non-reimbursed expenses. Because patients must depend upon their physician to determine the medical necessity of a given hospital admission, it is incumbent upon the physician to advise his patient (when appropriate) of potential noncoverage situations.

In order to conserve health care dollars and facilities, and in order to contain insofar as possible, continuing increases in the costs of health care, nearly all Blue Cross certificates exclude coverage for hospital stays which are not medically necessary, which are primarily for diagnostic testing or evaluation, or which are longer than medically required by the condition of the patient. Because the premium rates are based upon such exclusions, such claims must be disallowed.

In reviewing claims, the following criteria are generally applied:

- (1) Were there diagnostic procedures performed that could only be performed safely and effectively as a hospital inpatient? Examples of such qualifying procedures are cardiac catheterization, pneumoencephalography, ventriculography, cerebral angiography, and liver, spleen or kidney biopsies. However, radiological examinations of the G.I. tract, urinary tract (IVPs), EEGs, EKGs, organ scans and most blood or urine studies are safely and effectively performed on an outpatient basis and therefore would not qualify for inpatient benefits. Hospitalization for the convenience of the patient, his family, or the physician does not meet this criterion.
- (2) Was the patient's condition such that the medically indicated treatment and/or observation could only be safely and effectively provided on an

inpatient basis? Claims for serious and acute conditions pose no problems. On the other hand, payment of claims for patients whose symptoms or conditions are chronic and may only need a therapeutic program which can be carried out on an ambulatory basis and whose needed diagnostic studies do not meet criterion #1 (above), would have to be disallowed.

(3) Does the specific or definitive therapy provided require hospitalization? Examples of treatment meeting this criterion are major and certain minor surgical procedures, the administration of intravenous fluids, the frequent need for injectible narcotics or antibiotics or potentially toxic drugs.

On the other hand, examples of treatment not meeting this criterion might involve only oral medications, special diets, and physical therapy modalities such as hot packs or cervical collars.

When reviewing claims it is frequently necessary to request copies of certain patient records from hospitals. Because coverage decisions are frequently dependent upon the content of such reviewed records, problems can arise when the records are unclear or lacking in appropriate content. The confidentiality of these records is scrupulously maintained.

Every effort is made to be fair and equitable in adjudicating claims. If all physicians followed the general criteria as outlined, the problems and frustrations of all concerned could be significantly reduced.

Blue Cross-Blue Shield respects the physician's right to exercise his judgement in admitting and discharging patients and at no time will we interfere with this right. We are, however, charged with the responsibility of prudently expending the health care dollars entrusted to us by our subscribers by means of certificate exclusions properly administered.



## ASK BLUE SHIELD

### . . . ABOUT MEDICARE

#### Physician's Imprinted Label Improves Claim Processing Time

A physician's imprinted label on the SSA-1490 Request for Medicare Payment form gives the Part B Medicare carrier accurate information on the provider's identification—an item essential to faster claim processing and payments.

When you need imprinted labels they may be obtained by using a special mailing address and box number established by Blue Shield for Cook County. These requests should be addressed to:

Medicare Part B  
Blue Cross-Blue Shield  
Post Office Box 2218  
Chicago, Illinois 60690  
Attention: Provider Update Unit

When you submit an SSA-1490 form without an imprinted label, please complete Item 8, including your first name, last name, middle initial, address, zip code, telephone number and physician identification code number.

Newly licensed physicians without an identification code number should complete an SSA-1490 form and Item 8, with name, address, state license number, Social Security number and specialty, if any. A physician identification code number will be assigned by Blue Shield.

The imprinted label on the SSA-1490 form does not require the physician to accept assignment. To accept assignment, the assignment statement on the form must be checked and signed by the physician. Physicians who do not want to accept assignment are encouraged to complete and sign the 1490 for the beneficiary and to use their physician label to speed processing.

#### SIGNATURE REQUIREMENT ON CLAIMS

All assigned claims and all non-assigned claims with unpaid charges *must* have the patient's signature before payment can be made by Medicare. The exceptions to this rule are:

- (1) The patient is a public aid recipient and the IDPA number is shown in Item 5 of the SSA-1490.
- (2) The patient is deceased and the physician is accepting assignment. Indicate "Patient Deceased" in Item 6 of the SSA-1490.

A patient who is incapable of signing his name due to illiteracy or physical handicap may sign with a mark. This must be witnessed. The patient's name

and the signature and address of the witness must be shown in Item 6.

If a patient is physically or mentally unable to transact business, a friend or relative of the patient may sign for him. Item 6 should show the patient's signature, the name of the person signing in his behalf, and the relationship of that person to the patient. For example, "Joe Smith by Helen Jones, Daughter."

The administrator of a non-profit residential home may sign for the patient if he has the patient's power-of-attorney. Item 6 should show "Joe Smith by Adam Marks, Administrator, Home."

An employee of the physician or a clinic *may not* sign for the patient nor is it acceptable to show the patient's signature followed by the initials of the person signing for him. The forging of a patient's signature on an SSA-1490 is considered a misdemeanor under Federal Law.

#### Diagnosis Needed on Medicare Claims

A diagnosis is necessary for the Part B Medicare carrier to relate the services provided to the treatment of the illness or injury. It is also helpful if the diagnosis is included on the physician's statement to the patient when billing the patient directly. The diagnosis avoids the necessity for the Medicare carrier to contact the physician for the information when the patient files for benefits and neglects to properly complete Item 4 on the SSA-1490 Request for Medicare Payment form.

#### Notification of Withdrawals from Medicare Program

The Social Security Administration notified us that the following portable x-ray suppliers had withdrawn from participation in the Medicare program:

Northbrook Clinical and X-Ray Laboratory  
1775 Walter Avenue  
Northbrook, Illinois 60062

Provider Number: 14-9804  
Effective Date: June 1, 1976

United Health System, Inc.  
194 A. Skokie Valley Road  
Highland Park, Illinois 60040

Provider Number 14-9808  
Effective Date: June 1, 1976

# Editorials



## *Informed Consent*

A few weeks ago an editorial appeared in *The Medical Tribune* entitled "What the patient remembers." The meat of this article is worth repeating for those who did not read it. And for those who did, we wonder if they did anything about it? It deals with informed consent procedures so important in many malpractice claims.

The editorial deals with the experiences of Dr. George Robinson, a New York cardiac surgeon, and Dr. Abraham Merav, who used a tape recorder in all informed consent conversations with cardiac surgery patients at Montefiore Hospital in 1975. They discussed the diagnosis, the nature of the proposed operation, the prosthetic devices, benefits, risks, potential complications, and alternative methods of treatment.

Drs. Robinson and Merav repeated the consent interview with 20 of these patients who had had an uneventful post operative course. This second conversation was also recorded. After reviewing these tapes, Dr. Robinson reported that "Findings upon reinterview indicated generally poor retention in all categories. . . The poorest scores were achieved in the single category of potential complications, i.e. 10% primary recall and, with suggestion of appropriate responses, a secondary recall of 23% out of a possible 100% in this category. . . ." Of the 20 patients, 16 denied that certain major items had been discussed at all, and of these 13 denied having been informed on

multiple significant items of information.

Dr. Robinson deserves credit for his unique type of research. Physicians and surgeons who are in the high risk category for malpractice suits might benefit from this plan provided they have enough money left to buy a tape recorder after paying their insurance premiums. They should have a permanent record of their pre-operative discussion with the patient.

*The Medical Tribune* editorial goes on to say that a tape recording should also be made of the conversation when discussing potential side-effects of drugs.

The time may come when groups of physicians will find it expedient to tape all essential conversations. In addition, they will have a special room containing visual aids and files with printed pamphlets on appropriate medical subjects. A paramedic, nurse, or science writer will be in charge of the educational process and no prescriptions will be given or surgery done until the patient agrees that they understand. The agreement will be in writing and on the tape recorder.

We hope this never becomes necessary because it would again increase the cost of medical care and be a hardship on the patient.

T. R. Van Dellen, M.D.

*Editor*



## Guest Editorial

# Continuing Education for the Continuing Educator

*In 1972, ISMS invited the State's eight medical schools to join in a unique co-operative venture between profession and professional school—the Illinois Council on Continuing Medical Education. ICCME has worked quietly but effectively throughout the state since that time. To insure that all ISMS members know about ICCME services, we have arranged for members of that Council's Board to write a series of editorial reports. This is the sixth in that series.*

With increasing frequency those responsible for CME planning are asked to provide educational programs which are tailored to individual needs and result in improved patient care. The problems encountered in meeting these demands have highlighted the complexities of the CME planning process. While past expectations of the CME planner rarely extended past his ability to line up a series of lecturers, nowadays he must be a combination of William Osler, Mr. Chips, and Dale Carnegie. Because of the nature in which a CME planner is selected by the community hospital, few individuals are prepared for this complicated and critical role. This is not to imply lack of aptitude or intelligence. However, few health professionals have an occasion to systematically study the application of generally accepted principles of adult education to the process of continuing education for physicians. The need of CME planners to have opportunities to increase their planning skills has become an important concern of the Illinois Council on Continuing Medical Education.

During the past 18 months, ICCME has offered three intensive weekend workshops which have

provided an introduction to CME techniques. Thirty-six Illinoisans participated and uniformly found the experience useful in dealing with their CME problems. In June, 1976 a shorter on-site "Workshop in CME Leadership" was added to the list of training options provided by ICCME. Plans are now being made to expand these single topic workshops into a series of interrelated training sessions. Through didactic study and field work in the home setting, trainees in this new program will receive a comprehensive orientation in the skills of CME needs identification, selecting instructional methods, measuring CME program effectiveness, and group dynamics.

Time and energy are required to enhance planning skills; and Directors of Medical Education and other CME planners will need the encouragement of attending staffs and hospital administrators as they seek opportunities to increase their competence. Since everyone will benefit, continuing educators deserve our support as they pursue their own continuing education.

Donald F. Pochyly, M.D.

- 
- ▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.
  - ▲ **Milwaukee Sanitarium** { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.
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## *I'm Confused*

There are extreme demands to train paramedical personnel to shoulder some of the responsibilities of physicians and surgeons. There are pressures to allow optometrists to diagnose and treat eye disease, although they are not educated or trained to do so. Podiatrists are demanding the right to treat systemic illnesses which may effect the feet, although they, too, do not have the background to do this properly. These and numerous analogous trends are understandable in view of the rising cost of medical care, time- and pressure-burdens on M.D.s and D.O.s striving to maintain high standards of care, and the lack of availability of quality care to all segments of the population. And so what is a simplistic solution to a complex problem may sound great.

But, inevitably, paramedical treatment of medical and surgical problems would lead to two classes of medical and surgical care—the best and the next best—and from this would follow two standards or a “double standard” of care, something our medical profession abhors. Nor does it take any great stretch of the imagination to guess which segments of society will get which class of care. Can you imagine, for example, a woman receiving early genetic evaluation, ultrasonic, electronic, and biochemical monitoring and then having her baby delivered by a midwife? If, that is, she had a choice. For society may abrogate its right to a free choice if it accepts empty promises and a bill of goods.

*Joseph H. Skom, M.D.*

Joseph H. Skom, M.D.



# However you define in acute cystitis achieved an

**81%**  
achieved  
zero colony count/ml  
urine

**83%**  
achieved  
<1000/ml  
urine

\*In a new study 8 out of 10 patients with acute lower urinary tract infection, primarily cystitis, achieved sterile urine. All infections were nonobstructed. Susceptible organisms included *E. coli*, *Klebsiella-Aerobacter*, *Proteus mirabilis* and *Proteus vulgaris*.

No. of patients	Sterile urine	Clear culture <1000 organisms/ml urine	Clear culture <10,000 organisms/ml urine
406	81% (330)	83% (339)	88% (357)

Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey



consider the effect on  
coexisting glaucoma when  
you prescribe a vasodilator\*



a vasodilator that has not been  
reported to raise intraocular pressure

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TABLETS, 20 mg.

the compatible vasodilator

**Mead Johnson** LABORATORIES

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**\*Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

# Clinics for Crippled Children

## Scheduled for August

Twenty four clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will count sixteen general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing services. There will be seven special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- August 4 Hinsdale, Hinsdale Sanitarium
- August 5 Sterling, Community General Hospital
- August 5 Litchfield, St. Francis Hospital
- August 5 Lake County Cardiac, Victory Memorial Hospital
- August 9 Peoria Cardiac, St. Francis Children's Hospital
- August 10 Peoria, St. Francis Children's Hospital
- August 10 E. St. Louis, Christian Welfare Hospital
- August 11 Champaign-Urbana, McKinley Hospital
- August 12 Springfield, St. John's Hospital
- August 12 Kankakee, St. Mary's Hospital
- August 13 Chicago Heights Cardiac, St. James
- August 13 Division Cardiac, U. of I. Hospital, Center for Handicapped Children
- August 17 Rock Island, Moline Public Hospital
- August 17 Belleville, St. Elizabeth's Hospital
- August 18 Springfield Pediatric-Neurology, Diocesan Center
- August 18 Chicago Heights, St. James Hospital
- August 19 Rockford, Rockford Memorial Hospital
- August 19 Elmhurst Cardiac, Memorial Hospital of DuPage County
- August 19 Bloomington, Mennonite Hospital
- August 23 Peoria Cardiac, St. Francis Children's Hospital
- August 24 Peoria, St. Francis Children's Hospital
- August 25 Aurora, St. Joseph Mercy Hospital
- August 27 Chicago Heights Cardiac, St. James Hospital
- August 27 Evanston, St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on behalf of crippled children. ◀

## Obituaries

**Chwatal Herbert F.**, Downers Grove, died May 4, at his home. Dr. Chwatal, a 1935 graduate of Loyola University, practiced in the Chicago area.

**Ferenczy, Peter**, Chicago, died at Edgewater Hospital recently, where he was on staff. He was also on staff at Colombus Hospital. Dr. Ferenczy had practiced in this country since 1950.

**\*Foltz, Herbert Lee**, Chicago, passed away April 27th. A 1938 graduate of Stritch Medical School, Dr. Foltz practiced on the South West side of Chicago for 40 years.

**\*Klein, Seymour**, Chicago, passed away May 21 at Skokie Valley Community Hospital. Dr. Klein was Senior Attending Physician at Michael Reese Hospital and on staff's at Childrens Memorial, Edgewater and also Weiss Memorial.

**\*Levinson, Samuel A.**, Chicago, Died May 24th at Weiss Memorial Hospital. Dr. Levinson taught pathology from 1929 to 1960 at the University of Illinois College of Medicine. From 1960 until 1973 he was Chief Pathologist at Weiss Memorial Hospital.

**\*Lippert Stuart**, Jacksonville, died February 27 of this year. Doctor Lippert began his Illinois practice in 1949.

**\*McGue, Frank J.**, Elizabethtown, passed away suddenly March 24th. Dr. McGue is a 1952 graduate of Indiana University.

**\*Phifer, Frank M.**, Chicago, Died in Eureka, Illinois. Before his retirement he was chief of the department of urology at Illinois Central Hospital and attending urologist at seven other hospitals in the Chicago area. He was also professor emeritus at the Loyola University, Stritch School of Medicine.

**Theobald, Pierce W.**, Winnetka, died in May of this year. Dr. Theobald was senior attending physician at Augustana Hospital and Skokie Valley Community Hospital. He practiced for 31 years as an Eye, Ear, Nose and Throat Specialist.

*\*Indicates ISMS member*

*\*\*Indicates ISMS member and member of the Fifty Year Club*

**Israeli kibbutz doctors (English speaking) need help to provide primary care, develop patterns of care, teach medical students, etc. If you are able to provide a week or more of your time, write or call: Paul Drucker, M.D., 799 Amboy Avenue, Edison, N.J. 08817 (201) 548-2656 or Jerry Abrams, M.D., 190 Greenbrook Rd., N. Plainfield, N.J. 07060 (201) 756-8513.**



## Syphilis—CDC Recommended Treatment Schedules, 1976\*

A recent issue of the *Morbidity and Mortality Weekly Report* carried a copy of the latest revision of CDC Recommended Treatment Schedules for Syphilis. This report is reproduced in part here; for the complete report write: U.S. Department of HEW, Public Health Service, Center for Disease Control, Atlanta, Georgia 30333.

Few data have been published on the treatment of syphilis since CDC revised these recommendations in 1968. Penicillin continues to be the drug of choice for all stages of syphilis. Every effort should be made to document penicillin allergy before choosing other antibiotics because these antibiotics have been studied less extensively than penicillin. Physicians are cautioned to use no less than the recommended dosages of antibiotics.

**EARLY SYPHILIS** (primary, secondary, latent syphilis of less than 1 year's duration)

- (1) Benzathine penicillin G—2.4 million units total by intramuscular injection at a single session. *Benzathine penicillin G is the drug of choice because it provides effective treatment in a single visit.\** OR
- (2) Aqueous procaine penicillin G—4.8 million units total: 600,000 units by intramuscular injection daily for 8 days. OR
- (3) Procaine penicillin G in oil with 2% aluminum monostearate (PAM)—4.8 million units total by intramuscular injection: 2.4 million units at first visit, and 1.2 million units at each of 2 subsequent visits 3 days apart. *Although PAM is used in other countries, it is no longer available in the United States.*

Patients who are allergic to penicillin:

- (1) Tetracycline hydrochloride\*\*—500 mg 4 times a day by mouth for 15 days. OR
- (2) Erythromycin (stearate, ethylsuccinate or base)—500 mg 4 times a day by mouth for 15 days.

*These antibiotics appear to be effective but have been evaluated less extensively than penicillin.*

**SYPHILIS OF MORE THAN 1 YEAR'S DURATION** (latent syphilis of indeterminate or more than 1 year's duration, cardiovascular, late benign, neurosyphilis)

- (1) Benzathine penicillin G—7.2 million units total: 2.4 million units by intramuscular injection weekly for 3 successive weeks. OR
- (2) Aqueous procaine penicillin G—9.0 million units total: 600,000 units by intramuscular injection daily for 15 days.

*The optimal treatment schedules for syphilis of greater than 1 year's duration have been less well established than schedules for early syphilis. In general, syphilis of longer duration requires higher-dose therapy. Although therapy is recommended for established cardiovascular syphilis, there is little evidence that antibiotics reverse the pathology associated with this disease.*

Cerebrospinal fluid (CSF) examination is mandatory in patients with suspected, symptomatic neurosyphilis. This examination is also desirable in other patients with syphilis of greater than 1 year's duration to exclude asymptomatic neurosyphilis.

*Published studies show that a total dose of 6.0-9.0 million units of penicillin G results in a satisfactory clinical response in approximately 90% of patients with neurosyphilis. There is more published clinical experience with short-acting penicillin preparations than with benzathine penicillin G. Some clinicians prefer to hospitalize patients with neurosyphilis, particularly if the patient is symptomatic or has not responded to initial therapy. In these instances they treat patients with 12-24 million units of aqueous crystalline penicillin G given intravenously each day (2-4 million units every 4 hours) for 10 days.*

Patients who are allergic to penicillin:

- (1) Tetracycline hydrochloride—500 mg 4 times a day by mouth for 30 days. OR
- (2) Erythromycin (stearate, ethylsuccinate or base)—500 mg 4 times a day by mouth for 30 days.

*There are NO published clinical data which adequately document the efficacy of drugs other than penicillin for syphilis of more than 1 year's duration. Cerebrospinal fluid examinations are highly recommended before therapy with these regimens.*

\*These recommendations were established by the Venereal Disease Control Advisory Committee after deliberation with therapy experts (see MMWR: April 9, 1975, Vol. 25, No. 13).

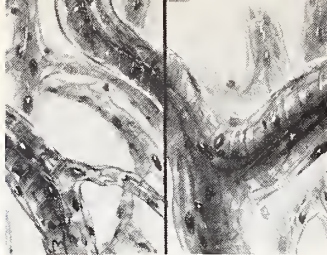
\*\*Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

This Bicentennial summer a concerted effort will be made to avoid a blood shortage in the Chicago area by asking that each person who regularly donates blood make a special effort to bring along someone who has never donated before.

Blood needs in the Chicago area are expected to rise by 10% in 1976 according to the Chicago Regional Blood Program, because more sophisticated medical and surgical techniques requiring blood are being performed for more people. This year Chicago will need about 240,000 units of blood—all from volunteer donors.



# When women outlive their ovaries...



The menopausal "flush" is believed to result from an autonomic nervous system imbalance due to estrogen deficiency. Here, illustration shows artist's interpretation of "normal" vs. dilated arteriole-capillary-venule network.

"It seemed like I was having one flush after another. It wasn't just a nuisance... it was a real problem."





# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## August, 1976

### Family Medicine

**NEWER DIAGNOSTIC TECHNIQUES IN LUNG DISEASE**  
For: Medical, paramedical, nursing. Lecture, August 4, 11:00 AM. Martha Washington Hospital, Chicago.  
Speaker: Norman Sollday, M.D., Asst. Prof. of Medicine, Northwestern Univ. School of Medicine. **CME Credit:** 1 hr. AMA Cat. 1; AAFP Elective. Fee: None. Sponsor, contact: Medical Staff, Martha Washington Hospital, 4055 N. Western Ave., Chicago 60618. Attn: Fernando L. Villa, M.D., Medical Director. Telephone: (312) 583-9000 x331. Co-Sponsor: Chicago Lung Association.

**SPECIALTY REVIEW COURSE FOR FAMILY PRACTICE**  
For: FP's 10½ day course. August 16-27. **CME Credit:** 98 hrs. AMA Cat. 1. Fee: \$98. Reg. Limit: 150. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

### Radiology

#### ABDOMINAL IMAGING, 1976

For: General Radiologists and Gastroenterologists. Postgraduate Course, August 25-27, 8:30-5:30 each day. Wieboldt Hall, Chicago. **CME Credit:** 21 hrs. AMA Cat. 1. Fee: \$175. Sponsor: Department of Radiology, Northwestern University Medical School and Northwestern Memorial Hospital. Contact: Harvey L. Neiman, M.D., Department of Radiology, Northwestern Memorial Hospital, Superior Street and Fairbanks Court, Chicago 60611. Telephone: (312) 649-2468.

### Sports Medicine

#### THIRD ANNUAL SPORTS MEDICINE SEMINAR

For: Team physicians, Trainers, Coaches. Symposium, August 28, Ramada Inn, Champaign, Illinois. Speakers: Lou & Charlotte Gomalar, Syndicated writers. Fee: \$7.50 (includes buffet dinner). Sponsor, contact: Edward P. Grogg, M.D., Carle Foundation & Carle Clinic, 602 West University Ave., Urbana, Ill. 61801. Telephone: (217) 337-3346. Co-sponsor: Illinois Academy Pediatrics.

## September, 1976

### Cardiovascular Disease

#### CURRENT TRENDS IN CARDIOVASCULAR DISEASE

For: General Practitioners. 3-day tutorial program, Sept. 17, 12 Noon-8:00 PM; Sept. 18, 8:00 AM-5:00 PM; Sept. 19, 8:00 AM-1:00 PM. University of Chicago. Speaker: Oglesby Paul, M.D., Northwestern University Medical School. **CME Credit:** 20 hrs. AMA Cat. 1; Amer. Soc. Contemporary Med. & Surg. Fee: \$200. Reg. Limit: 200. Reg. Deadline: Sept. 15. Sponsor, contact: John G. Bellows, M.O., Ph.D., Director, American Society of Contemporary Medicine and Surgery, 30 N. Michigan Ave., Chicago 60602. Telephone: (312) 236-4673. Co-sponsor: Center for Continuing Education, University of Chicago.

### Family Therapy

#### WORKING WITH FAMILIES WITH AN ADULT HANDICAPPED MEMBER

For: Physicians and Mental Health Professionals. One-day Workshop. Sept. 3, 9:00 AM-4:30 PM. Chicago. Speaker: Lyle Anderson, M.D., and Darlene Dietz, R.N. **CME Credit:** 7 hrs. AMA Cat. 1. Fee: \$30. Reg. Limit: 50. Sponsor, contact: Belinda M. Stone, Secretary for Workshops/Conferences, The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Telephone: (312) 440-1414. Co-Sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

## Medical Education

### MEDICAL EDUCATION AND THE CONTEMPORARY WORLD

For: All MD's. 2-day symposium. Sept. 13-14, 9:00 AM-5:00 PM each day. Blackstone Hotel, Chicago. Fee: \$15, \$7 (med. students). Reg. Deadline: Sept. 1. Sponsor, contact: Jane Whitener, Staff Assistant, Univ. of Illinois College of Medicine, Office of Continuing Education Services, 1853 W. Polk St., Room 144, Chicago 60612. Telephone: (312) 996-8025.

### Neurosurgery

**THIRD ANNUAL POSTGRADUATE COURSE IN BASIC SCIENCE AND CLINICAL REVIEW OF NEUROSURGERY**  
For: Neurosurgeons, Neurologists, Diagnostic Radiologists. Postgraduate Course. Sept. 7-11, 8:00 AM-5:15 PM each day except Saturday 8:00 AM-12:30 PM. Northwestern University Medical School, Thorne Hall. **CME Credit:** 35 hrs. AMA Cat. 1. Fee: \$375 (pract. physicians); \$175 (Residents). Sponsor: Northwestern University Medical School, Division of Neurological Surgery. Contact: Jacob R. Suker, M.O., Associate Dean, Postgraduate Education, Northwestern Univ. Medical School, 303 E. Chicago Avenue, Chicago 60611. Telephone: (312) 649-7947.

### Pediatrics

#### PEDIATRIC SURGERY FOR PEDIATRICIANS

For: Pediatricians. Postgraduate course, Sept. 9-10, 8:30 AM-4:30 PM. Children's Memorial Hospital, Chicago. **CME Credit:** 11 hrs. AMA Cat. 1. Fee: \$100. Reg. Limit: 200. Sponsor: Children's Memorial Hospital. Contact: Jacob R. Suker, M.O., Dept. of Postgraduate Education, Northwestern University Medical School, 303 East Chicago Ave., Chicago 60611. Telephone: (312) 649-7947. Co-sponsor: Northwestern University Medical School, Dept. of Postgraduate Education.

### Plastic Surgery

#### 3rd ANNUAL POSTGRADUATE COURSE IN PLASTIC SURGERY

For: Plastic Surgeons. Postgraduate Course, Sept. 14-16, 8:30 AM-4:30 PM. Northwestern Memorial Hospital, Chicago. **CME Credit:** 20 hrs. AMA Cat. 1; American College of Surgeons. Fee: \$250. Sponsor, contact: Jacob R. Suker, M.D., Associate Dean of Postgraduate Education, Northwestern University Medical School, 303 East Chicago Ave., Chicago 60611. Telephone: (312) 649-7947. Co-sponsor: American College of Surgeons.

### Sexual Therapy

#### INTEGRATION OF SEXUAL THERAPY INTO ONGOING PSYCHOTHERAPY

For: Physicians and Mental Health Professionals. Two-day workshop, Sept. 17-18, 9:00 AM-4:30 PM. Norris Center, Evanston, Illinois. Speaker: E. Lee Doyle, Ph.D., Private Practice, Dallas, Texas. **CME Credit:** 14 hrs. AMA Cat. 1. Fee: \$70. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Attn: Belinda M. Stone, Secretary for Workshops/Conferences. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

## October, 1976

### Anesthesiology

#### REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING

For: All MD's. 5 day course. Oct. 4-8. **CME Credit:** 40 hrs. AMA Cat. 1. Fee: \$300. Reg. Limit: 8. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Telephone: (312) 733-2800.

### Couples' Therapy

#### MULTIPLE COUPLES' THERAPY

For: Physicians and Mental Health Professionals. One-day workshop, October 1, 8:30 AM-5:00 PM, Chicago. Speaker: Charles Kramer, M.D., and Jeannette Kramer, F.I.C./C.F.S. **CME Credit:** 8 hrs. AMA Cat. 1. Fee: \$30. Reg. Limit: 50. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Attn: Belinda M. Stone, Secretary for Workshops/Conferences. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

### Emergency Medicine

#### 1976 ACEP/EDNA SCIENTIFIC ASSEMBLY

For: Emergency Physicians and Nurses. Scientific Assembly. October 11-15. Superdome, New Orleans, Louisiana. Fee: varies. Sponsor, contact: American College of Emergency Physicians and Emergency Department, 241 E. Saginaw, East Lansing, MI 48823. Attn: Martha J. Muth, CME Coordinator. Telephone: (517) 332-6544.

### Oncology

#### SECOND ANNUAL POSTGRADUATE SEMINAR—THE MANAGEMENT OF COMMON NEOPLASMS: HEAD, NECK, GYNCOLOGICAL AND UROLOGICAL TUMORS

For: Physicians, graduate students in specialties designated—Obstetrics & Gynecology, Urology, Oncology. Postgraduate Seminar in Oncology (2½ days), Oct. 21 & 22, 8:30 AM-5:00 PM; Oct. 23, 8:30 AM-12 Noon. Northwestern Memorial Hospital, Chicago. **CME Credit:** 17 hrs. AMA Cat. 1. Fee: \$150. Reg. Limit: 100. Reg. Deadline: October 21. Sponsor, contact: Northwestern University Cancer Center, Northwestern University Medical School, 303 E. Chicago Avenue, Chicago 60611. Attn: John S. Schweppe, M.D., Chairman, Cancer Center Education Committee. Telephone: (312) 649-8674 or 642-9294.

### Otolaryngology

#### ANNUAL OTOLARYNGOLOGIC ASSEMBLY

For: Physicians in specialty. Assembly—1 week. October 16-22, 8:00 AM-5:00 PM. University of Illinois, Eye and Ear Infirmary, Chicago. Speaker: Emanuel M. Skolnik, M.D., Chairman of the Assembly. **CME Credit:** 42 hrs. AMA Cat. 2. Sponsor, contact: Dept. of Otolaryngology, University of Illinois, 1855 W. Taylor Ave., Chicago 60612. Attn: Mrs. Evelyn Seman. Telephone: (312) 996-6582.

### Varied—Multidiscipline

#### CARLE FOUNDATION DAY

For: General Practitioners. Lecture Series and Evening Guest Speaker. October 27, Ramada Inn, Champaign, Illinois. Fee: None. Sponsor, contact: Carle Foundation and Carle Clinic, Dept. of Neurology, 602 W. University Ave., Urbana, IL 61801. Attn: James B. Worrell, M.D. Telephone: (217) 337-3180.

## Workshop in CME Leadership

### HOW WOULD YOU LIKE TO TAKE A CRACK AT THIS ONE?

As President of your hospital medical staff, you receive a report from the Medical Audit Committee showing an unexpected increase in cases of peritonitis on the pediatric and general medicine services during the first quarter of the year. There were 15 cases, four of whom died. All four had ruptured appendices. There was an epidemic of gastroenteritis in the community during that quarter. The Executive Committee decides to bring in an expert to lecture on peritonitis. Only a fourth of the pediatric and medical staff, plus three surgeons and two nurses, show up—and when you check attendance against patient records, of all the staff who handled the peritonitis cases, only *one* signed in for the lecture.

**SOUND FAMILIAR?** If so, your hospital suffers from three chronic problems common among in-hospital CME programs:

1. Not every patient receives the full quality of care that modern biomedical science, and contemporary physicians, can provide.
2. The *kind of CME most often offered fails* to reduce medical care deficiencies identified by audit.
3. The observation is constantly made that “those who need CME the most never attend.”

**YOU CAN SOLVE THESE PROBLEMS...** by mastering one essential concept: shared leadership. For *clinical* problems, doctors routinely share responsibility by referral to other specialists. By contrast, for CME this rarely works; you can't just dump the “CME problem” on another staff committee. What **does** work is: Medical staff officers take full responsibility for in-hospital CME, *sharing that task with colleagues*.

**WORKSHOP IN CME LEADERSHIP** . . . a short (3-hour) session, available anywhere in Illinois, can help you learn the basic techniques for building an effective CME program in your hospital. (It'll also help you enable your colleagues to satisfy the new mandatory CME law, conveniently and effectively.)

**FOR DETAILS** . . . write “Workshop in CME Leadership” on your prescription form and mail it to . . .

ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 Chicago, IL 60603  
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## MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION\*

Each capsule contains 50 mg. of Dyrenium<sup>®</sup> (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.



Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

#### Warning

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings:** Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia ( $>5.4$  mEq/L) has been

reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and

BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

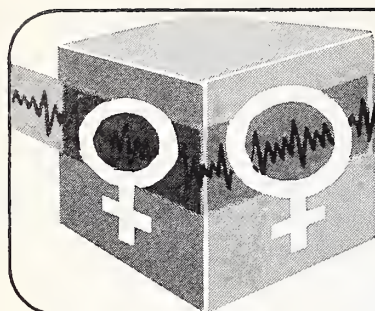
**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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## "If" for a Doctor's Wife

*(With apologies to Rudyard Kipling)*

If you can keep your head when patients all about you  
Are losing theirs, insisting that the doctor call;  
If you can trust your husband with women all about him  
And never feel a jealous twinge at all;  
If you can learn that people are demanding,  
And care nothing for a doctor's private life,  
Yet, under tension, still be understanding  
And try to be a model, patient wife.

If you can hear a group discuss a diagnosis  
About which you know facts on which they err,  
And never breathe a word, nor mention a prognosis,  
Although, to do so, would cause quite a stir;  
If you can plan a dinner party  
And find you're left alone to entertain,  
And never show your inner thoughts or disappointment  
And not be tempted to complain;

If you can play the role of dad as well as mother,  
Explaining to the youngsters why this has to be;  
And also doctor Dad, yourself and all the children  
(For doctors' families hate to bother an M.D.);  
If you can cook a meal at noon or midnight  
And serve it fast, and with a pleasant smile,  
And, as you eat, hear many cures and symptoms  
With the telephone ringing madly all the while;

If you can dress in style and not be ostentatious,  
Remembering that the public watches every move you  
make;  
And, when you're tempted to be rude, be gracious,  
And often laugh, although your heart would break;  
If you can feel *you* chose this man to marry  
And be a loving, cheerful, understanding wife—  
You'll find your burdens pleasant ones to carry,  
And, what is more, you'll lead a full and happy life!

—HELEN ULRICH

Excerpted from *MDs Wife*, March, 1967.



WORKS HOUR AFTER  
HOUR AFTER HOUR  
AFTER HOUR AFTER  
HOUR AFTER HOUR  
AFTER HOUR AFTER  
HOUR AFTER HOUR  
AFTER HOUR AFTER  
HOUR AFTER HOUR

# Tedral<sup>®</sup> SA

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital.

**SUSTAINED ACTION**

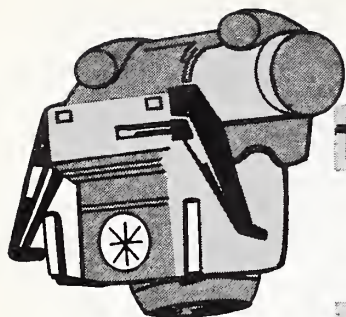
The special long-acting oral bronchodilator...one tablet provides 12 hours of protection... b.i.d. dosage offers round-the-clock prophylaxis against asthma symptoms.

**TEDRAL<sup>®</sup> SA Sustained Action** — **CAUTION:** Federal law prohibits dispensing without prescription. **Indications:** Tedral SA is indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. It may also be used prophylactically to abort or minimize asthmatic attacks and is of value in managing occasional, seasonal, or perennial asthma. Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage. Tedral SA is an adjunct in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes. **Contraindications:** Sensitivity to any of the ingredients; porphyria. **Warning:** Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING. **Precautions:** Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma. **Adverse Reactions:** Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported. **Dosage:** Tedral SA. **Adults**—(average prophylactic or therapeutic dosage)—one tablet on arising and one tablet 12 hours later. Tablets should not be chewed. **Dosage in children under 12** is not recommended because usage has not been established. **Supplied:** Tedral SA. Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in unit dose—package of 10 x .10 strips (N 0047-0231-11). Full information is available on request.



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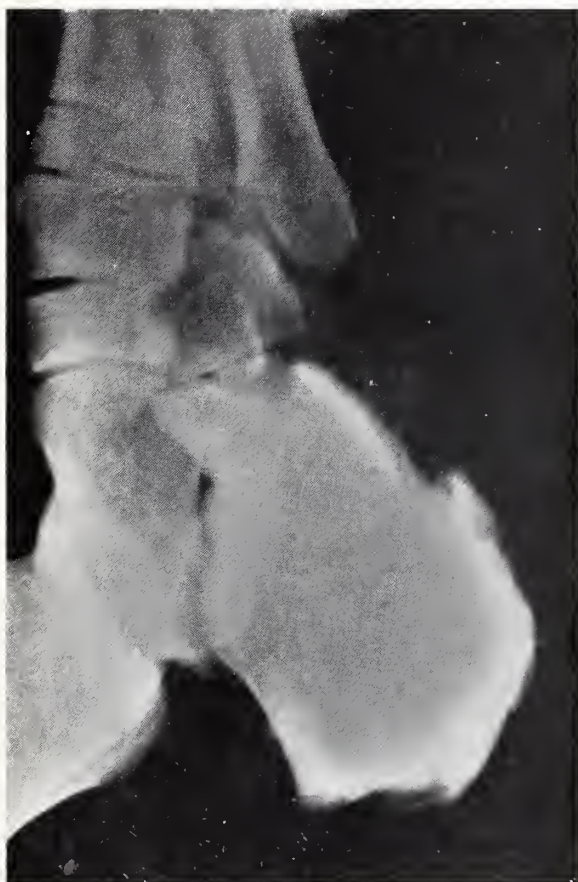
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## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This is a 23 year old male with a history of painful heels.



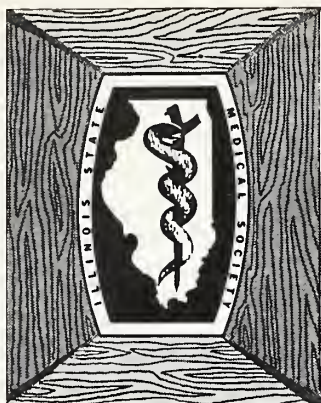
**Figure 1**

**What's your diagnosis?**

1. Osteomyelitis
2. Tuberculosis
3. Reiters syndrome
4. Pagets disease

*(Answer on page 86)*





# I M J

Illinois Medical Journal

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## Assessment of Left Ventricular Function with Apexcardiography

### A Study in Patients Six Months to Two Years After Acute Myocardial Infarction

BY SUDARSHAN KUMAR, M.B., M.R.C.P., F.R.C.P. (C) AND  
GEORGE KROLL, M.D./CHICAGO

*In order to evaluate function of the left ventricle, apexcardiograms were analyzed in thirty-five patients six months to two years after acute myocardial infarction. None of the patients had angina pectoris or heart failure. No significant valve disease, pulmonary heart disease or systemic hypertension was present in any patient. Infarction was anterior wall in twenty-eight and inferior wall in fifteen patients. Abnormal "A" wave was present in twenty-five (71%), abnormalities in systolic wave in twenty-two (62%) and abnormalities in rapid diastolic wave in nine (25%) instances.*

*These findings were interpreted to be due to elevation of the left ventricular end diastolic pressure, alteration in ventricular wall motion and changes in the distensibility characteristics of the left ventricle.*

*This study indicates that gross disturbance in the function of the left ventricle may be present in apparently asymptomatic patients after an acute myocardial infarction.*

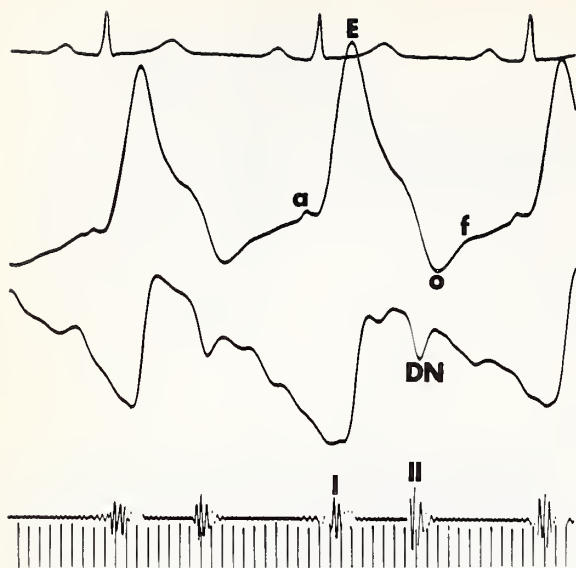
The apexcardiogram is a low frequency record of the precordial vibrations. Many studies have revealed a close relationship between the apexcardiogram and hemodynamic events in the left ventricle.<sup>1-3</sup> In clinical setting the amplitude of A wave has been used to assess the left ventricular end diastolic pressure<sup>3-6</sup> and the character of its systolic wave has provided useful information with regards to left ventricular wall motion.<sup>7-9</sup> Previous studies have described changes in the apexcardiogram in patients symptomatic with ischemic heart disease. We have evaluated apexcardiograms of 35 patients who have had (1) acute myocardial infarction six months to two years previously and (2) who have been without heart failure or angina pectoris since

that episode. Our observations indicate that severe disturbance in the function of left ventricle as detected by this non-invasive technique may be present for an extended period of time after recovery from acute myocardial infarction.

### Patients and Methods

Thirty-five male patients who had been treated in the Coronary Care Unit of VA Research Hospital for acute myocardial infarction six months to two years previously were studied. The diagnosis of myocardial infarction was based on history of chest pain together with the presence of abnormal Q waves, ST and T wave changes in the electrocardiogram and serum enzyme changes compatible with acute myocardial infarction.





**Figure 1.** From above downwards: electrocardiogram, apexcardiogram, external carotid arteriogram and phonocardiogram recorded at the apex in a healthy young man of forty-five years. Atrial contraction is characterized by an "A" wave which is less than 16% of OE. After the inscription of E point there is a rapid decent of the curve with slight shoulder to the O point. Diastole is ushered in at the O point and the junction of rapid filling and slow filling is marked by F. The first and second heart sound are clearly seen. DN indicates the dicrotic notch of the carotid artery. Sequence of inscription same in all illustrations.

The electrocardiographic localization of infarction was in the anterior wall in 20 patients and in the inferior wall in 15 patients. Persistent ST segment elevation seen occasionally in anatomical aneurysm of the left ventricle was not present in any patient. None of the patients had angina pectoris or clinical heart failure after infarction. All were normotensive. There was no evidence of significant pulmonary, valvular or congenital heart disease. All had normal sinus rhythm. Mild to moderate enlargement of the cardiac silhouette was present on X-ray in seventeen patients.

The procedure was fully explained to each patient with particular emphasis on its atraumatic nature. After thorough clinical evaluation, the patient was placed on a couch and made comfortable in the left lateral position. The microphone (PS-IB) was firmly but not tightly strapped at the point of maximal impulse. An additional similar microphone was strapped or hand held on the right carotid artery. The apexcardiogram, phonocardiogram, external carotid arteriogram and electrocardiogram were recorded simultaneously in mid-expiratory apnea.

The paper speed was 75mm/sec. with vertical lines representing time interval of 40m/sec. The equipment used for recording was the multi-channel Electronics for Medicine, DR-8, Oscilloscopic photographic recorder.\* To minimize the possibility of artifactual curves, the tracings were obtained by the same observer (SK) and with the same equipment. Careful palpation of the apex beat and precise placement of the microphone at this point were judiciously practiced. Tracings thus obtained were carefully analyzed and compared with the normals in this laboratory (Fig. 1) and with those described by other workers.<sup>2,10-13</sup> An abnormality was considered present only when it appeared constantly in at least twenty complexes of the apexcardiogram.

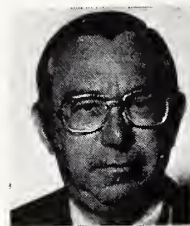
## Results

The apexcardiogram was considered normal in seven out of 35 patients. In 28 patients (80%) the following abnormalities were observed alone or in combination:

1. **Large A wave:** (defined as = or >16% of the total apexcardiographic complex) was present in twenty-five patients (71%).
2. **Abnormalities in Systolic Component:** In 22 patients (62%) the apexcardiogram showed abnormal systolic contour. For descriptive purposes this abnormality was further categorized as follows:

\*Time constant 2.5 sec., pulse mode .1-10 cycles, phono mode 30-1000 cycles.

SUDARSHAN KUMAR, M.B., M.R.C.P., F.R.C.P.(C), is Associate Professor of Medicine, Northwestern University Medical School and Director of the Cardiac Catheterization Unit, V.A. Lakeside Hospital. He obtained postgraduate training in England and at Tufts and Harvard Medical Schools, Boston. Dr. Kumar is a Fellow of the American College of Cardiology and the American College of Physicians.



GEORGE KROLL, M.D., D.D.S., is Associate Professor of Clinical Medicine at Northwestern University School of Medicine and Chief of the Cardiovascular Section, V.A. Lakeside Hospital. He is also a Fellow of the Council on Clinical Cardiology of the American Heart Association, a Fellow of the American College of Cardiology, and a Fellow of the American College of Physicians.

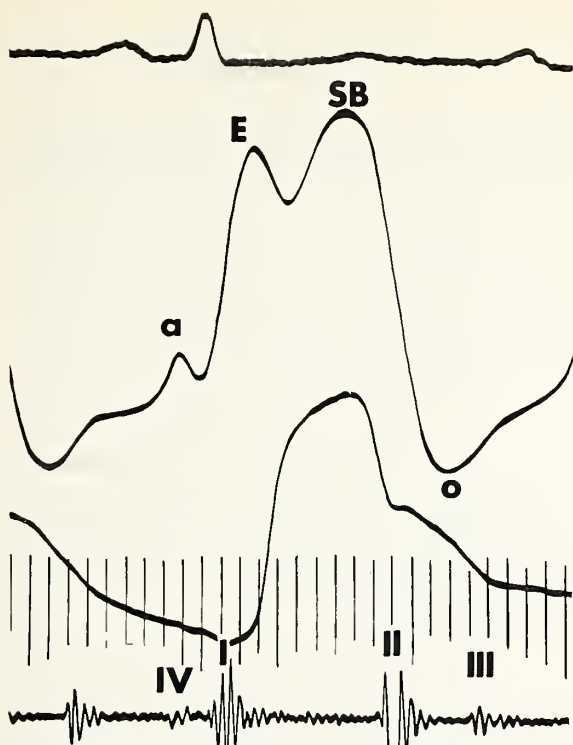


Figure 2. There is a prominent A wave corresponding to the fourth heart sound. The E point corresponding to the beginning of carotid upstroke is well defined; this is followed by a trough and then a crest which occurs in mid-late systole (SB = systolic bulge). The shape of the systolic component resembles letter M. A third heart sound is present in the phonocardiogram.

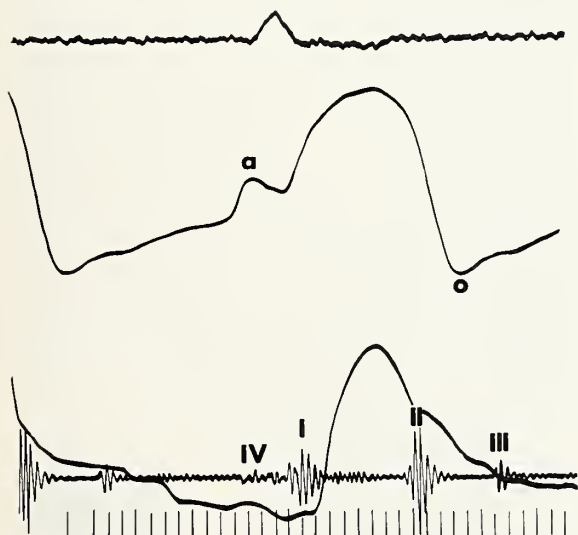


Figure 3. There is a prominent A wave in the apexcardiogram. The E point is not defined. The systolic contour shows a positive wave throughout systole and resembles a camels' hump. Third and fourth heart sounds are present.

a. **The M Shaped Apex:**—Sixteen patients.

In this type of abnormality the E point was distinctly defined with a trough in the early systole followed by a rounded somewhat sustained crest (bulge) in the mid to late systole (Fig. 2).

b. **The Camel Hump Apex:**—Six patients.

In this type of systolic abnormality the E point was not defined. The upstroke of the apexcardiogram merged imperceptibly into a round bulge which lasted throughout systole (Fig. 3).

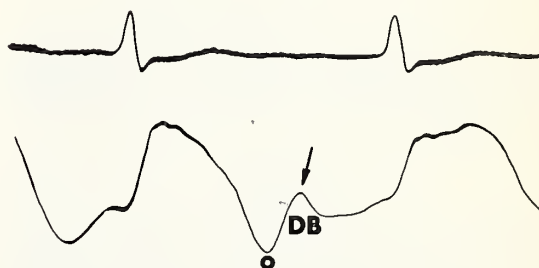


Figure 4. External carotid arteriogram and phonocardiogram not shown. Note the prominent crest at the junction of rapid and slow filling waves. DB = Diastolic bulge.

3. **Abnormalities in Diastolic Component:**

Abnormalities in the diastolic component were present in nine cases (25%).

a. **Prominent Rapid Filling Wave:**

Two patients. In two patients the rapid filling wave was abnormal ( $\geq 40\%$  of total complex).<sup>2</sup> In one of the two the rapid filling wave resembled a bulge (diastolic bulge = DB in Figure 4).

b. **Poorly defined Rapid Filling Wave:**

Seven patients. In this type of abnormality the rapid filling wave was poorly differentiated and the O point was shallow. The tracings were similar to those described occasionally in mitral stenosis, although no clinical or radiologic evidence of mitral stenosis was present in any of these patients. (Fig. 5).

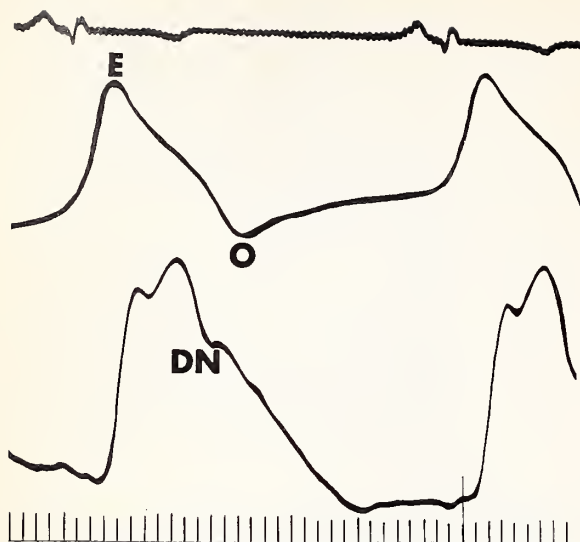


Figure 5. In systole the E point is well defined. In diastole the rapid filling is abbreviated. The junction between rapid and slow filling is not clear.

### Discussion

Benchimol and Dimond first reported changes in the apexcardiogram of patients with ischemic heart disease.<sup>5</sup> In their study however, the emphasis was primarily on the height of A wave in particular relation to total height of the apexcardiographic complex. Relatively little information is available with regards to changes in the other components—systolic and diastolic—of the apexcardiogram. Furthermore, most published studies included patients usually with acute myocardial infarction, those suffering from angina pectoris or heart failure on the basis of coronary artery disease. The purpose of this study was to evaluate a select group of patients who have recovered from acute myocardial infarction and thereafter have not been disabled by any of the clinical symptoms of ischemic heart disease.

### Abnormal A Wave

The commonest abnormality in our patients was prominent "A" wave. This finding was in agreement with studies of Benchimol and Dimond.<sup>5</sup> Abnormal A wave has been shown to correlate well with elevated left ventricular end diastolic pressure.<sup>4-6</sup> It reflects forceful atrial contraction to maintain adequate cardiac output. It does not indicate the presence of ventricular "failure" in the conventional sense but rather a stage of compensation in which there may be reduced distensibility of the left ventricle.

### Systolic Configuration

The second most frequent finding was alteration in the systolic configuration of the apexcardiogram. Two patterns of abnormality were discernible. In the one—sixteen patients—the E point was clearly defined followed by a positive wave (bulge) in mid to late systole giving rise to a M shaped pattern. Lane et al<sup>8</sup> found this pattern in thirteen patients, eleven of whom had asynergy on cineventriculography and two of whom had hypertrophy of the left ventricle. The end diastolic pressures and volumes in their patients were variable. In the other type of systolic change the E point was not defined, the bulge was pansystolic and resembled a camels' hump. This pattern was found in six of our patients and was similar to that described by Lane et al<sup>8</sup> in 12 patients with larger areas of asynergy, elevated end diastolic pressure and increase in end diastolic volumes.

### Diastolic Configuration

Changes in the rapid filling wave of diastole were found in nine instances. In seven it was diminutive and in the two, strikingly exaggerated. Conditions characterized by inflow obstruction or those which impose volume overload on the left ventricle are frequently associated with changes in the rapid filling wave.<sup>10,16</sup> Thus it is absent or significantly reduced in mitral stenosis, increased in mitral insufficiency and in hyperkinetic heart of chronic anemia, thyrotoxicosis etc. The O point which marks the beginning of rapid filling in the apexcardiogram corresponds only approximately to the point of crossing over of left atrial and left ventricular pressure.<sup>2-3</sup> Travel et al postulated that "rapid filling is initiated by active ventricular elongation or expansion and is to a certain extent independent of the timing of the mitral valve opening," i.e. diastolic suction, for which there is experimental evidence.<sup>17-19</sup> In the frame work of these considerations it is possible to explain changes in the rapid filling wave on the basis of distensibility characteristics of the left ventricle. Thus impaired distensibility of the left ventricle was probably an important factor in the production of diminished rapid filling wave in seven of our patients. A markedly increased rapid filling wave was present in two of our patients. None of these had evidence of mitral insufficiency. In contrast to the spiky configuration illustrated by Lane et al<sup>8</sup> it was more rounded,  
(Continued on page 86)



# Complications of Fetal Monitoring: Scalp Abscess and Osteomyelitis

BY SHIG YASUNAGA, M.D./URBANA

*Eight scalp abscesses secondary to fetal monitoring, one progressing to osteomyelitis, are reported. The infant with osteomyelitis may have developed sepsis from the scalp abscess which localized to the frontal bone.*

*Infants undergoing fetal monitoring should be carefully observed postnatally for signs of induration and erythema at the monitoring site to prevent a serious infection.*

Monitoring of the fetal heart rate at the time of delivery through the use of a scalp electrode has received increasing clinical application in many centers.<sup>1-4</sup> Complications from this procedure to the disrupted fetal scalp are rare in the literature. Hon<sup>5</sup> reported the development of a 2 mm. pustule on the neonate's scalp which cleared uneventfully; the monitoring clip had been left in the scalp for twelve hours. Cordero<sup>6</sup> reported seven abscesses secondary to fetal monitoring: six were sterile, one abscess grew the same organism recovered from the mother's vagina.

Fetal scalp monitoring was initiated at Jefferson Davis, a city-county hospital, in October, 1969. In 1023 monitoring procedures, complications have been few and minor except for eight scalp abscesses, one of which progressed to osteomyelitis. The first six infants with scalp abscess (including the infant that developed osteomyelitis) were born in a six-week period in 1970; two more recent cases of scalp abscesses occurred one year later. The first group of infections was traced to the use of poorly resterilized scalp clips. If a scalp electrode is to be reused, instructions found in the literature<sup>7</sup> should be followed: that is, autoclave the clip and reuse only if the insulation, silver and silver chloride electrode are intact. The two other abscesses were due to faulty technique of electrode application. No endoscopic cone was used to shield the clip from vaginal contamination.

## Review of Case Studies

The cases are summarized in Table 1. Of particular interest is case #1, where the abscess progressed to osteomyelitis. This patient's history and hospital course are described in detail below.

### Case 1

The patient is a 3300 grams (7# 4½ oz.), white female infant born to a gravida 6, para 5, 32-year-old mother. One month prior to delivery the mother was found to have congestive heart failure with abdominal cramps, dyspnea, a sudden weight gain of ten pounds and 3-4+ pitting edema. She was hospitalized and treated with diuretics and a low salt diet. Active labor developed on the 28th hospital day. Because of the mother and fetus' high risk status, scalp monitoring was initiated two hours prior to delivery. Although several episodes of bradycardia were noted, the newborn infant's condition at birth was good, with a one minute Apgar score of 8. The membranes had ruptured approximately 19½ hours prior to delivery; the total duration of labor was 4 hours, 53 minutes.

The initial physical examination of the neonate at eight hours of life revealed a term infant in no apparent distress with good activity and a loud cry. Hydration and nutrition were both satisfactory. The heart rate was 140 beats per minute and the respiration rate was 40 per minute. An indurated area and puncture site secondary to fetal monitoring were noted on the examination.

On the third day of life, the infant had a bilirubin level of 14 mg% with a direct fraction of 0.2 mg%. The mother's blood type was O negative; the newborn infant's was A negative with a negative direct Coombs. The infant responded well to 48 hours of phototherapy. The etiology of this jaundice was thought to be blood incom-



SHIG YASUNAGA, M.D., is Director of the Neonatal Intensive Care Unit at Mercy Hospital and Assistant Dean for Clinical Curriculum Development at the University of Illinois, Urbana.

patibility rather than infection, as indicated by the low direct fraction.

The infant was discharged on day six to the parents in apparent good health. No further mention of the monitoring site was made after the initial examination, nor were cultures taken or antibiotics administered. The patient was afebrile throughout her initial hospital course and at no time was she noted to appear septic.

On the eleventh day of life, the mother noted a 2 cm mass "the size of an olive" on the infant's head in the frontal area which drained a purulent bloody discharge. Since there was a history of fetal monitoring, the patient was referred to the general hospital and subsequently hospitalized. The admission X-ray showed circumscribed densities in the frontal bone compatible with thickening due to inflammatory origin, diagnosed in follow-up films as osteomyelitis (Fig. 1). How-



**Figure 1. Osteomyelitis as a complication of fetal scalp monitoring (case 1). Circumscribed densities in the frontal bone compatible with thickening due to inflammatory origin can be seen.**

ever, cultures of the scalp abscess grew no organism. On her second hospital day, the patient developed an erythematous lesion on the dorsum of the right foot which grew staphylococcus. Blood cultures drawn at that time were negative. The infant received a two-day course of aqueous penicillin I.M. and a seven-day course of Staphicillin intravenously. Although the scalp abscess was never specifically treated, she did receive these nine days of antibiotic therapy. The patient remained afebrile and was dismissed after a total hospitalization period of eleven days, at 22 days of life.

## Cases 2 through 8

Maternal fever and amnionitis were not present in any of the series and premature rupture of membranes or prolonged labor were seldom present. Intrapartum infections apparently were not responsible for these scalp abscesses. The duration of monitoring probably had no correlation with the development of abscesses: fetuses have been monitored up to twelve hours at this center with no signs of infection postnatally. The authors have seen abscesses as a complication of forceps delivery, but in all of the cases in this report the double-clip puncture marks identifying fetal monitoring sites were seen with the abscess (Fig. 2). Fetal scalp sampling has also been



**Figure 2. Scalp abscess as a complication of fetal monitoring. The double-clip puncture marks which identify fetal monitoring sites are seen with the abscess (case 8).**

implicated in the development of abscesses in the newborn period;<sup>8</sup> however, in none of these cases was fetal blood sampling taken.

Induration and erythema at the monitoring site preceded every abscess and were first noted from six hours after delivery (case 4), up to four days of age (case 7). The induration, erythema and subsequent abscess with purulent discharge were noted and treated during the newborn infant's initial hospital course except in case 1 who was discharged, then readmitted at eleven days of life for the spontaneous drainage of a scalp abscess with a radiologic diagnosis of osteomyelitis.

Masses on the scalp measured from small pustules to 2 x 2 cm. Every abscess contained purulent discharge which drained spontaneously without incision. Organisms were cultured from four of the seven abscesses: cases 2, 3, 5 and 6 grew *Enterococcus*, *E. coli*, *Peptostreptococcus* and *Staphylococcus aureus*, respectively. Cerebral



**Table 1**  
**Clinical data of neonates with scalp abscesses secondary to fetal monitoring**

Case	Delivery Record				Abscess Course				
	Rupture of Mem.	Dur. Labor	Indications for Monitoring	First Noted	Organism Exudate	Blood	CSF	X-ray	Hosp. Days
1	19'30"	5'	fetal bradycardia	day 9	N.G.	N.G.	—	osteo	6,11
2	10'30"	16'	poor progress in labor	day 3	Enterococcus	—	—	neg.	8
3	25'	24'	fetal bradycardia	36'	E. coli	N.G.	—	—	11
4	18'	40'	poor progress in labor	6'	(cultures lost)	N.G.	N.G.	—	8
5	4'	10'	fetal bradycardia	12'	Peptostreptococcus	N.G.	—	—	9
6	13'	13'	vaginal bleeding	day 2	Staphylococcus aureus	N.G.	—	—	16
7	(no record)	12'	poor progress in labor	day 4	N.G.	N.G.	N.G.	neg.	11
8	9'	13'	poor progress in labor	day 3	N.G.	N.G.	N.G.	neg.	8

spinal fluid and blood cultures grew no pathogens. All the patients in our series responded to antibiotics in various combinations of Ampicillin, Kanamycin, Staphcillin and Colymycin with good response. Local treatment consisted of a hexachlorophene wash with topical antibiotic ointment (Neosporin) application. All radiographic follow-ups were negative (except for case 1). Hospital days for these newborn infants with abscesses secondary to fetal monitoring ranged from six to sixteen days.

### Discussion

The advantages of fetal monitoring outweigh the danger of the relatively rare complications. In our series eight scalp abscesses, one of which progressed to osteomyelitis, occurred in over 1,000 procedures, an incidence of 0.78%. Pathogens not related to maternal or intrapartum infection were cultured from four of the eight abscesses. All apparently resulted from a break in sterile technique during fetal monitoring. Although no organisms were found in the cerebral spinal fluid or blood of any of these patients, bacteria in the presence of a traumatized scalp can certainly lead to sepsis in the neonate. One abscess (case 1) did progress to osteomyelitis, which is often hematogenous. This infant could have had sepsis which localized in the frontal bone before her second hospital admission. With the exception of this first case who was dismissed and later readmitted with osteomyelitis, discharge orders on all neonates developing abscesses were withheld. Without early recognition and treatment of induration and erythema at the

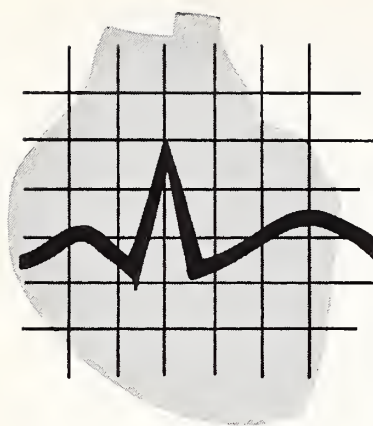
fetal monitoring site, the potential for sepsis and osteomyelitis is apparently greater.

Strict sterile technique must be observed during fetal monitoring. All neonates undergoing this procedure should be carefully observed in a hold area in the nursery for signs of induration and erythema at the monitoring site or sepsis, and skull radiographs taken in those infants developing scalp infections. Discharge should be withheld until the risk of an abscess with its serious complications is no longer present. ◀

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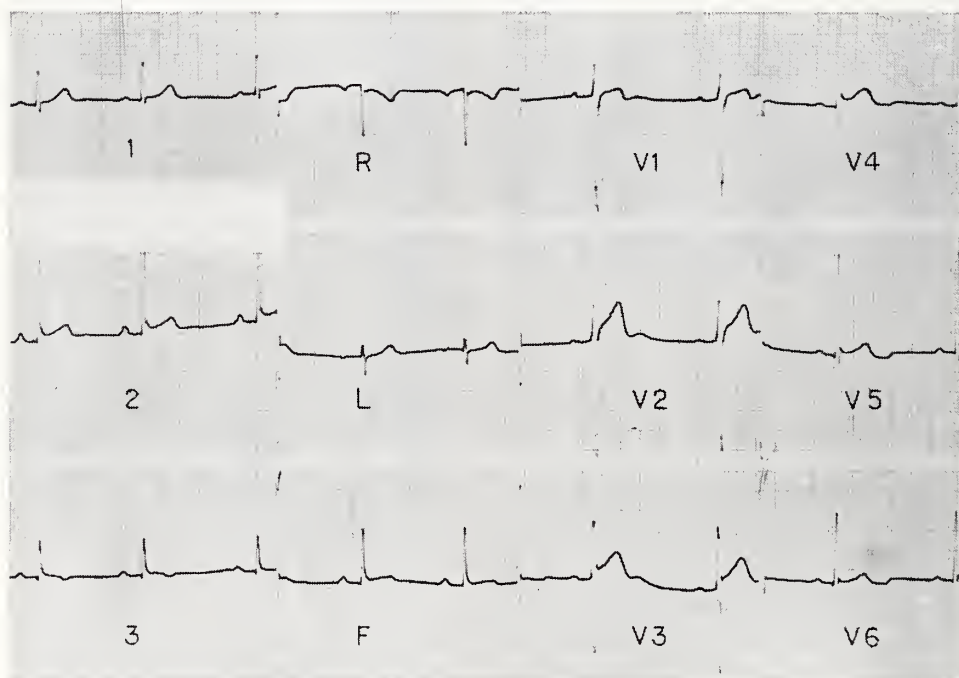




## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

A 32-year-old school teacher was seen in the office for evaluation of stabbing, left precordial pain made worse by inspiration. Examination revealed an anxious white male without cardiovascular abnormalities.



### Questions:

#### 1. The electrocardiogram taken shows:

- A. Acute pericarditis.
- B. Acute inferior wall myocardial infarction.
- C. Acute anterior wall myocardial infarction.
- D. Inferior wall myocardial ischemia.
- E. None of the above.

#### 2. Further evaluation of this patient should include:

- A. A more detailed history.
- B. Review of previous electrocardiograms.
- C. Immediate hospitalization.
- D. Exercise electrocardiography.
- E. Coronary arteriography.

(Answers on page 86)

# How to Start a CME Program in Your Hospital or Medical Society

BY LEONARD S. STEIN, PH.D., EXECUTIVE DIRECTOR, ICCME

*Any group of physicians can start their own CME program, following a model that has proved successful in a wide variety of situations—in your hospital or county society, or for members of a specialty spread over several counties or other large area.*

*Three premises underlie the procedure outlined: (1) Most physicians feel a strong need for personal/professional growth,<sup>1</sup> an urge to improve their ability to deal well with patient problems confronted; (2) most doctors carry a heavy workload, and therefore (3) they want to learn as efficiently as possible.*

**ON THOSE PREMISES:** Find six colleagues who share a learning interest with you and start a study group, an informal seminar.<sup>2</sup>

## Select Subject-Area

Begin by identifying some problem-area(s) likely to interest a number of your colleagues, from one or more of these sources: (a) census of admission/discharge diagnoses in your hospital [or in the several hospitals from which you anticipate drawing group-members], (b) medical care evaluation studies from those same hospitals, (c) published reports on frequency/seriousness of diagnoses and patient problems seen by your specialty, (d) patient-problem inventories from office practice, (e) public health statistics, (f) a rough frequency count of the kind of problems you hear discussed in the doctors' lounge or at meetings of your medical society, or (g) your *own* clinical/scientific concerns and interests.

From these sources, select one or two broad subjects and derive a tentative name: *e.g.*, "Allergy Study Group," or "Cardiovascular Conference." Use that name in recruiting initial group members so potential participants can decide whether the subject-area fits their interests and needs.

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*This paper is excerpted from a new ICCME pamphlet, that spells out in detail how to initiate an effective CME program, including three special worksheets that can add efficiency to your planning. Copies of the full pamphlet are FREE to Illinois physicians (M.D. or D.O.) and CME sponsors; just write "How to Start a CME Program" on your prescription form, and mail to Illinois Council on CME, 55 E. Monroe St., Suite 3510, Chicago IL 60603; or telephone (312) 236-6110.*

*To those interested from outside Illinois, a charge of \$2/copy is necessary to cover cost of printing, handling, and shipping.*

## Why Six Colleagues?

With yourself, that makes seven. Soon after you start regular meetings, probably one or two participants will drop out *either* (a) for reasons of personal schedule, family, professional or other obligations, *or* (b) because of preference for other CME methods. This leaves you with four or five—an absolute minimum for effective learning, but large enough for fruitful discussion of shared problems.

## Scheduling

At your first meeting, select a definite regular meeting schedule, so group members may block that day and hour out of their regular routines. Weekly or bi-weekly meetings usually prove most efficient. Schedule each session for *not more* than two hours; most study groups limit their sessions to 60 minutes. Plan a *maximum* of 26 to 40 weekly (or 20 bi-weekly) meetings a year.

It may seem foolish to mention the importance of starting and ending at the stated hours—but this does make a difference. Learning effectiveness is enhanced; in the long run group members will be happier, as they acquire the habit of *arriving* promptly and scheduling other activities for *after* the stated ending hour.

## Equipment

The only *essential* equipment is (a) a seminar-type table big enough for 12-15 (to allow space for additional members as they join), and (b) a large chalk-board, at least 4' x 6'—preferably green—plus chalk and eraser.

The *table* is important for two reasons: (a) the physical configuration—facing each other—strongly stimulates free, open, discussion, and thereby enhances sharing of knowledge, insights, and understanding; (b) a table is preferable to chairs in a circle, because from time to time you'll want to take notes or do other writing; you'll also need space for patient records, X-rays, etc.

The *chalkboard* is a further stimulus to fruitful discussion. The chairman, or a recorder, should record (concisely) key points made during discussions—including contradictory viewpoints. Frequently, resolution of controversial and/or difficult points is easier if all can look together at the same set of words, altering them until you agree that you have solved the problem at hand. On other occasions, you'll want to enter laboratory results or other detailed facts that provide background for discussion, so they will be readily in sight for everybody's easy reference.

### **The Study Notebook—Looseleaf Binder**

A highly useful aid is an individual three-ring binder for each member. The kind with a large pocket inside the front and/or back covers is convenient for keeping miscellaneous items. For little more, you can have each individual's name imprinted on his/her notebook and the name of your study group.

Reason for the binder: It provides an easy way to keep personal notes, pertinent hand-out material, *etc.*, for future reference—and thus avoids the habit of making notes on scraps of paper or the backs of envelopes that eventually get thrown out.

### **Audio-Visual Aids**

Begin with the firm determination to use audio-visual techniques *as little as possible*. Available evidence suggests they contribute little to physician learning;<sup>3,4</sup> and they are expensive—especially video-tape playback machines. While popular, the typical tissue slides prepared by pathologists have limited value for the clinician: much more useful are pictures of clinical signs and symptoms—and if yours is an in-hospital learning group, bedside rounds provide more realistic "pictures" than photographs.

Despite the abuses of audiovisual techniques in CME, one machine is likely to prove necessary: a 35 mm. slide projector. Another aid which remains popular and useful among physicians is

the printed word, books and journals.<sup>5</sup> An ideal meeting room is the hospital library: when no one in the group can remember a fact that discussion has shown to be central to an issue, learning is improved enormously if the fact can be found instantly in a standard textbook or journal.

### **Clarifying Learning Needs**

In recruiting your group, you may well discover that all of you see exactly what you want to learn more about. On the other hand, as the Scots poet Robert Burns wrote:

*"O wad some Power the giftie gie us  
To see oursels as ithers see us!"*<sup>6</sup>

These poetic words touch a bit of truth about all humans: We are seldom able to see our faults and virtues except with some outside help. Most learners of any age—including doctors—find that a general interest in "learning more" about some topic is usually insufficient to insure effective learning achievement. Needed is some method or procedure to translate that general interest into "learnable" form.

A related consideration is also crucial for effective shared learnings: A group atmosphere or tone of mutual respect—i.e., full freedom for each member to speak freely without fear of denigration, to speculate, even to err. This does not deny the value of vigorous disagreement. Rather, a sense of freedom will encourage *constructive* disagreements, as well as enable those less knowledgeable or competent on specific points to accept easily the advice and help of colleagues. As organizer of the group, you can contribute strongly to the development of this kind of atmosphere, starting at the first session: make sure everyone has full opportunity to speak; avoid remarks that even *suggest* negative reaction to anyone's ideas. In time, other members will pick up this habit from you—with resulting increase in group learning effectiveness.

### **Basic Clinical Craftsmanship**

As you proceed through the specific tasks of identifying learning needs, formulating objectives, selecting effective methods, and evaluating learning outcomes—you may find useful the advice offered by Edmund Pellegrino in late 1975, as a broad guiding principle for your study activity. He holds that "the fundamental problem . . . [of CME] is to maintain and to refurbish physicians' basic clinical craftsmanship"—the fundamental skills of H&P, analysis of clinical data, and selecting Dx/Rx procedures best for the pa-



tient in the light of *all* relevant factors. Indeed, he argues that most errors in patient management are related to deficiencies in these skills, rather than in lack of knowledge about new treatment modalities.

He quickly adds a word on the importance of keeping up with new biomedical knowledge, further remarking: "But really useful new information is rare, and becomes a mandatory acquisition only when it can materially affect the patient's outcome. Properly cultivated, the fundamental clinical skills can protect the patient from lack of the newest or latest information. *Such information, however, cannot protect against inept clinical craftsmanship, and indeed often gives only the illusion of competence.*" [Italics added.]

He also suggests four other domains for CME that constitute important dimensions of any subject your group chooses for its learning:

- a) Understanding how to critically evaluate new pharmacotherapeutic agents;
- b) New technologies useful in clinical care, such as computers;
- c) Bioethics and the law of medicine; *and*
- d) Skill in working with the ever-growing variety of health professionals whose support is crucial to successful patient management.<sup>7</sup>

### Low Financial Cost

Assuming (a) your group grows to ten members during its first year, (b) that 1976 prices remain valid for a while, and (c) that you have to buy everything your group needs [chalkboard, 35 mm. slide projector and screen, *etc.*]*—the cost is still very low for a self-initiated, self-study group—about \$10/hour of learning—far less than the cost of two days at a medical school CME course or a meeting of your specialty society—counting tuition, travel, room and meals, and loss of patient income for the period. Costs for the second and subsequent years will likely be half or less than that.*

### Superior Learning Achievement

While no concrete evidence proves it, the weight of contemporary judgement by experts on CME is that this kind of self-learning is the most effective kind of continuing professional education for *most* physicians on *most* subjects, because:

1. *Relation to daily work.* All your study-group's activities will be related directly to your daily practice.
2. *Learning by doing.* Everything you learn

will be through your own efforts. For most doctors, this is the most effective way to learn. The University of Wisconsin's ongoing study of physician learning indicates that over half of medical practitioners report they learn best in this manner.<sup>8</sup>

3. *Evaluation.* Few formal CME courses offer systematic evaluation of learning achieved; even those that do at best provide a pre- and post-test of changes in cognitive knowledge but *no* evidence as to change in physician performance. *By contrast*, your personal study club has a built-in peer review system in its free discussion of mutual problems—regardless of the skill or precision with which you conduct *formal* evaluation. Further, all the evaluation done will focus on clinical performance rather than information alone—and that ultimately is what CME is all about.

### Personal Growth, Stimulate Other Colleagues

Every time you confront a difficult problem on which you ask for help—formally from a consultant, more often *informally* from a colleague in a "corridor consultation"—you learn something. The same is true when another doctor asks *you* for help.

A study group formalizes and regularizes this interchange, providing a steady, systematic, flow of *learning* communication with colleagues. Equally important, it helps to build a set of personal/professional relationships that lead naturally to increased consultation on the tough cases because (a) you'll all *know* what each can do best, (b) you'll feel free to admit to fellow group members the *need* for help, and (c) you'll improve your self-understanding of your own skills and knowledge, your strong points and weaknesses, and therefore *know* when to seek help, and when to offer it to others.

### Problem-Solving Skill, Relevance

As suggested by the quotation from Pellegrino, good clinical performance flows from skill in analysis and solution of problems, rather than gaining new medical knowledge alone. A discussion group of colleagues, focusing on the difficult cases each sees, is the single best way to strengthen your analytic skills.

One reason this is so is that everything learned in your study group will be *relevant* to your on-going patient problems—for the obvious reasons, plus another one: Group discussion

among colleagues *guarantees* relevance; if anyone wanders off into immaterial or irrelevant directions, others quickly bring the discussion back to the right track. Every member is there because he/she *wants* to be, and is not about to waste time on nonsense.

### It Belongs to Us!

Finally, this kind of study group is effective because it will be yours—the psychic property of every group member. (That's one reason most such groups attract additional members.) You will have collectively planned every step in the learning process—identified the learning needs you feel, selected the subjects to fit those needs and formulated the objectives you think important, planned the learning methods appropriate to those needs and objectives, and devised your own plans for evaluation.

In doing all this for yourself, you avoid two major inhibitions on effective CME: (1) the denigrating effect of hearing a visiting expert tell you things that (a) you already know, (b) are irrelevant to your needs, and/or (c) lie beyond your level of competence and interest such as latest research findings on some narrow aspect of biomedical science; (2) time wasted in travel, hearing lectures unrelated to your local practice problems, discussing with strangers problems that may or may not fit your local situation. ◀

### Acknowledgements

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# MEN OF MEDICINE, 1776-1976

## Early Medical Societies

BY HAROLD M. CAMP, M.D., *dec.\**

In reviewing the available early histories of Illinois, as well as the early medical journals and lay press, one observes that there were many medical societies organized in this state even before 1850. Information concerning a number of them has been obtained from one of the oldest newspapers in this area, the *Edwardsville Spectator*, which published reports of meetings of societies dating as far back as 1817.

This newspaper reports that, prior to the admission of Illinois to the Union in 1818, under the old Illinois Territorial Act, a Territorial Medical Practice Act was developed and under mandate, two district medical societies were formed. A resolution was approved which stated: "Whereas well regulated medical societies have been found to contribute to the diffusion of true science, and particularly to knowledge of the healing art, therefore, for the purpose of regulating the practice of physic and surgery, this law is enacted." Two districts were formed; one east and one west of the third principal meridian. The ordained duty of the members was to examine students, give diplomas, charging therefore ten dollars.

Apparently little heed was given to this enactment, for the year following Illinois' entrance to statehood "an Act for the establishment of medical societies" was passed. It directed that the state should be divided into four medical districts "in each of which there shall be a board of physicians," and it specifically stated that "it shall be the duty of each and every physician of such districts to attend meetings," and without sufficient excuse, a fine was to be exacted! They

were to elect officers, examine students, collect \$10.00 for diplomas issued, and see to it that those not complying with the provisions of the act be disqualified from collecting debts from their practice. Another section of the act provided for the registration of births, deaths and diseases, the reports to be transmitted to and published in some newspaper. Failure to follow these provisions would result in a fine of \$10.00. Another section of this bill provided for the examination of bills rendered by physicians for exorbitant charges, the adjustment and return of such surplus as might be unreasonably made. This law was repealed by the legislature in 1821.

In 1824, a bill was again brought before the legislature to organize the medical profession under state control. This legislative action was prompted by a popular demand for reform in the medical situation made reprehensible by the presumption of the unqualified to treat the sick.

The *Edwardsville Spectator* carried several notices for meetings of the First District Medical Society of the State of Illinois. This district society was obviously functioning, as Dr. John Todd, President, published a report of an epidemic of fever as related by Dr. J. J. Crabb, Belleville, at one of its meetings. The statement was made "that the disease answers the description of a unit defined by Dr. Rush, bilious and malignant." The annual meeting of the First District Medical Society was held at Edwardsville the second Monday of May, 1821, and was noted in the call signed by Dr. Henry Perrine, Secretary. In the call it was stated that "punctual attendance is particularly requested, as business of importance will be laid before the meeting."

The Second District Medical Society was likewise functioning, evidenced by a report published May 29, 1820, by William L. Reynolds

\*Dr. Camp began to serve the Illinois State Medical Society as Secretary in May 1924. He was elected Treasurer of the Society in May, 1941, and continued in the dual capacity as Secretary-Treasurer until 1959.



of the Kaskaskia Medical Society and given by Hugh Steel of Brownsville in Jackson County, telling of health conditions prevailing in that county.

These societies were the first medical societies to be organized in Illinois. The Medical Society of Illinois was organized in 1840 with John Todd, President, and C. F. Hughes, Secretary. Efforts were made to keep this Society alive, but only a few meetings were held.

In December, 1849, an official call went out from the Ottawa Medico-Chirurgical Society, asking for a meeting to be held in Springfield on January 1st to organize an Illinois State Medical Society. The efforts of the Aesculapian Society of the Wabash Valley were also petitioned by the Ottawa Society. Later, on account of bad roads and frozen waterways, the call was changed to the first Tuesday in June, 1850. This meeting resulted in the organization of the Illinois State Medical Society which has been active to the present time.

### Early County Medical Societies

Information has been found concerning a number of county medical societies organized in various parts of the state. Morgan County had a short lived medical society in 1846, organized at Jacksonville. In 1847 there was an organization instituted at Ottawa called the Medical Society of LaSalle and adjoining counties and this, too, soon subsided. The LaSalle County Medical Society was organized in Ottawa on July 29, 1853, but no evidence is available to show subsequent meetings. The first Whiteside County Medical Society was organized July 22, 1851, but it also existed only a short time.

The Chicago Medical Society was founded in 1850. Dr. Levi Day Boone, who formerly had practiced in Southern Illinois, came to Chicago in 1836, during which year he aided in forming the Cook County Medical Society. As Secretary, he published an article entitled "Improvement in Medical Science" in *The Chicago Democrat*, October 1, 1936. In this article Dr. Boone stated, "The physicians of Chicago have recently constituted a society for the improvement of their profession . . . and have directed me (by resolution) to give notice through your paper that the first meeting of the Society will be held at the office of the Chicago Insurance Company. . . ."

There is no evidence of subsequent meetings or of other medical societies formed in Cook County until the organization of the Chicago

Medical Society on April 15, 1850. The preliminary meeting was held in the office of Drs. Levi Boone and Brockholst McVickar. Dr. David Rutter was made chairman of the proceedings, in which Dr. Nathan Smith Davis took an active part. Dr. Levi D. Boone was elected President, Dr. Erial McArthur, Vice-President, and Dr. Brockholst McVickar, Secretary. At this meeting, Drs. Boone and John Evans were selected as delegates to the American Medical Association. Among those present at the organization meeting were Drs. Daniel Brainard, W. B. Herrick, Edwin G. Meek, J. Herman Bird, J. V. Z. Blaney, Samuel O. Richey, Philip Maxwell, Levi D. Boone, Brockholst McVickar, David Rutter, Erial McArthur, John Evans and Nathan Smith Davis.

The first medical society in Peoria was established in 1846. It was reorganized in 1847, then became the Peoria Medical Society in 1848. This same year, a medical society was formed in Rock Island, mainly through the efforts of members of the faculty of the Rock Island Medical College. The Adams County Society was organized in Quincy on March 28, 1850. During the 1850's many county societies were organized. Information relative to the organization of these early medical societies is collected in the *Northwestern Medical and Surgical Journal* and the writings of Dr. William O. Ensign, an organizer of a number of central Illinois societies, a President of the Illinois State Medical Society, and for many years designated as the Official Historian of the State Society. Dr. Ensign stated that most of these earlier societies were of short duration. Quite a number were reorganized several times until, through the efforts of the Illinois State Medical Society, permanent county societies were ultimately organized and maintained.

### District and Regional Medical Societies

Records are still available to show that many societies were organized in Illinois composed of members from several counties. Some of these were formed prior to the reorganization meeting of the State Medical Society in 1850. A few have been maintained to the present time, but the majority of them functioned for a few years and then disbanded.

### The Aesculapian Society of the Wabash Valley

The Aesculapian Society of the Wabash Valley is said to have been the first interstate society organized west of the Allegheny Mountains. It

was officially organized in 1846 and incorporated in 1847. Drs. David Adams, Elisha C. Banks and J. M. Boyle appeared before the Illinois legislators and, in response to their petition, the society became a regularly chartered institution on February 17, 1847. It was first incorporated under the name of "Lawrenceville Aesculapian Medical Society." Dr. Elisha C. Banks of Lawrenceville was its first President, and Dr. David Adams was the second presiding officer.

The Society in 1849 met at Mt. Carmel, Illinois, and instructed its Secretary to correspond with the Ottawa Medico-Chirurgical Society with reference to appointing delegates to a convention to be held in Springfield in 1850, with the object of reactivating the Illinois State Medical Society.<sup>†</sup>

The Aesculapian Society grew rapidly. Within a relatively short time the majority of its members lived outside of Lawrence County, although they came, in general, from the communities near the Wabash River Valley. The name of the Society was, therefore, changed to the Aesculapian Society of the Wabash Valley and the bill of incorporation was properly changed. In the early dates of this Society, the meetings were of two days duration. For many of its members, this meant a day's journey going to the meeting and another day for the return trip home, thus compelling them to be away from their work for as long as four days.

Many prominent members of the Aesculapian Society were likewise prominent in the activities of the Illinois State Medical Society. Dr. Samuel Thompson of Albion, a charter member of the Aesculapian Society, was elected as the second President of the State Medical Society. Dr. Thomas D. Washburn, who moved from Lawrenceville to Hillsboro in 1856, was elected President of the State Society in 1876. Other members of the Aesculapian Society who became presidents of the Illinois State Medical Society were Drs. William M. Chambers, Charleston 1860; James S. Steele, Grand View, 1865, and G. W. Albin, Neoga, 1871.

At a meeting of the Society held at Paris, Illinois, in 1854, a committee was selected to pre-

pare a memorial and petition to be presented to the state legislature for "the suppression of quackery." Dr. Charles Johnson, chairman of this committee, was directed to take the petition to the legislature and to use his influence on the members to secure passage of a law which would protect the public from injuries inflicted by medical pretenders. The committee was not able to secure its passage.

Together with a committee from the Illinois State Medical Society, a committee was appointed by the Aesculapian Society to petition the state legislature to pass an act which would create a State Health Department. Efforts made at each biennial session for some twenty years to pass this legislation eventually (1877) resulted in the approval and organization of a State Health Department and a Medical Practice Act.

The Aesculapian Society of the Wabash Valley deserves much credit for its aid in reactivating the Illinois State Medical Society in 1850, for the development of a Medical Practice Act, and also for the development of the Illinois State Health Department.

### **Rock River Medical Society**

The Rock River Medical Society was organized at Rockford, February 17, 1846, with Dr. J. C. Goodhue as President. It was stipulated that there be a semi-annual and an annual meeting. Apothecaries were admitted to its membership and one apothecary was among its organizers. Dr. Daniel Brainard, upon joining this Society, stated that "it was the first medical society organized upon so extensive a scale in this region." Among the early members were Drs. William O. Chamberlain, S. Allen Paddock, W. W. Welch and Ephraim Ingals. At the 1847 annual meeting held in the Rockford Court House, Dr. L. Clark was President.

No records are available to show that meetings were held after 1850.

### **Ottawa Medico-Chirurgical Society**

The Ottawa Medico-Chirurgical Society was organized at Ottawa, January 1, 1849. Believing in the advisability of having an active statewide medical organization, this Society was the first to issue a call for the reorganization meeting which was held at Springfield on June 4, 1850. A circular was issued and sent to several existing societies in the state to get their support

<sup>†</sup>Medical historians differ in this matter. Some state the initiative was taken by the Ottawa Society, while others give credit for initiating the venture to the Aesculapian Society. It seems quite possible that the idea of having one statewide medical organization was considered by these two older medical societies at approximately the same time. Both desired to keep up with the ever-changing medical practice, to exchange experiences with other members of the profession, and to discuss the recent discoveries being published in the medical journals. The desirability of establishing a code of medical ethics was likely discussed at these early meetings.



for the convention to be held in Springfield on January 1, 1850. The Aesculapian Medical Society of the Wabash Valley concurred in this request and acted as co-sponsors. These facts, together with the actual account of the reorganization meeting of the Illinois State Medical Society in 1850, were reported in the 1849-50 issues of the *Northwestern Medical and Surgical Journal*.

### **Medical Society of Upper Illinois**

This Society was organized at Lacon on July 2, 1850. It was to comprise the counties of Marshall, Bureau, Stark and Putnam and was to be auxiliary to the Illinois State Medical Society. Officers were: President, Albert Reynolds, Magnolia; Vice-President, Robert Boal, Lacon; Secretary, S. Allen Paddock, Princeton; and Treasurer, Uri P. Golliday, Lacon. Most of these physicians were prominent in the early meetings of the Illinois State Medical Society. Following reorganization of the State Society, the Medical Society of Upper Illinois sent official delegates to the annual meetings. From information which is available, it seems quite evident that this Society did not hold many meetings.

### **Fox River Valley Medical Association**

The Fox River Valley Medical Association was organized at a meeting held in Aurora on February 1, 1850. In 1852, the members of this Association met and formed the Bi-County Medical Society of Kane and McHenry Counties. An organization meeting was held in Aurora in September 1864, when a reorganization was made under the name of the Fox River Valley Medical Society. Apparently this Society did not flourish, as another reorganization meeting was held in Aurora in September, 1874. In 1895, the membership of this Society was reported as 60.

### **Union Medical Association of Southern Illinois**

According to the *Northwest Medical and Surgical Journal*, this society was organized at Vandalia in 1856. Dr. George W. Hotchkiss was President, and Dr. W. D. Green was Secretary. No further information is available to show that subsequent meetings were held.

### **The Military Tract Medical Association**

That portion of Illinois designated as the Military Tract pertains to "a section of Illinois set apart under an act of Congress, May 6, 1812,

as bounty lands for soldiers in the war with Great Britain beginning that year." This tract comprised 2 million acres, which later was increased to 3½ million acres. In 1821, the tract was a part of the then gigantic county of Pike, which included most of northern Illinois. As the population increased, new and smaller counties were formed so that the Tract embraced all or part of the counties of Calhoun, Pike, Adams, Brown, Schuyler, Hancock, McDonough, Fulton, Peoria, Stark, Knox, Warren, Henderson, Mercer, Henry, Bureau, Putnam, and Marshall.

"Pursuant to previous notice, physicians from the counties of Bureau, Henry, Knox and Stark met at Kewanee in 1866, to organize a district medical society." Nineteen physicians were present from the four counties. Temporary officers were selected and, after some little discussion, it was decided that a Constitution and By-Laws should be developed and adopted at this first meeting. The association was to be designated as the Military Tract Medical Association. Physicians in good standing in the counties of Bureau, Henry, Stark, Knox and Warren were to constitute the membership. Members were to be governed by the Code of Medical Ethics of the American Medical Association. Meetings were to be held twice a year. The following officers were elected: President, A. H. Thompson, Princeton; Vice-President, H. Nance, Kewanee; and Secretary-Treasurer, George H. Scott. Five official delegates to the Illinois State Medical Society were selected at this meeting. The initiation fee was set at \$1.00.

Meetings were held regularly, the membership increasing as the number of counties increased. Gradually the counties of Henderson, Mercer, and Rock Island were added to the list. Members were also approved from Keokuk, Davenport, Fort Madison and other eastern Iowa cities, and from Hannibal and Louisiana, Missouri. In keeping with many other early medical societies, committees were appointed on tuberculosis, obstetrics, medicine, surgery and therapeutics, each to report the latest developments in these respective fields during the preceding year.

Interest in the Association increased until about 1900 when the attendance at the semi-annual meetings began to decrease. A two-day meeting was held in Peoria in October, 1908, with Dr. S. C. Stremmel of Macomb as presiding officer. An excellent program had been arranged and Peoria physicians had planned an interesting schedule of entertainment for the members.



In his closing remarks, Dr. Stremmel reported that it was becoming difficult to get enough members to the meetings to constitute a legal quorum; that membership dues for that year amounted to only \$18.00 and the expenses were \$90.00, and he believed it was time seriously to consider disbanding. After much discussion it was voted to disband or, at least, no definite date for a future meeting was set. The old officers were re-elected to wind up the affairs of the Association. A motion was made that any funds remaining in the treasury after the payment of all bills should be turned over to the Legislative Committee of the Illinois State Medical Society. The motion was unanimously approved.

The Military Tract Medical Association had been recognized by the Illinois State Medical Society as a participating organization and one entitled to send official delegates to its annual meetings each year. A list of these delegates, as shown in the minutes of the Association\*\* contain the names of several physicians who had been or would become the President of the State Medical Society and many others whose names have been prominent in the affairs of the Society.

### **The Iowa and Illinois Central District Medical Association**

During the summer of 1866, the Scott County (Iowa) Medical Society appointed a committee to investigate the possibility of organizing a medical society with members in eastern Iowa and western Illinois, within a radius of fifty miles of the Twin Cities. Letters were sent to physicians residing in this area, and on November 7, 1866, a large number of physicians met in Davenport and organized the Iowa and Illinois Central Medical Association. A Constitution and By-Laws were adopted, and Patrick Gregg of Rock Island was elected President. Within a relatively short time, most of the physicians residing in Davenport, Rock Island, Moline, and surrounding towns in Illinois and Iowa were members. Meetings were held quarterly, rotating the place of meeting. Committees were appointed to report on prevailing diseases, obstetrics, surgery, medicine, new remedies and phthisis. Reports were given by these committees at each meeting.

### **North Central Illinois Medical Association**

In the spring of 1870, Dr. James Whitmire of

\*\*The complete minutes of the Military Tract Medical Association were presented to the Illinois State Medical Society. They are now safely housed in the archives of this Society at the John Crerar Library in Chicago.

Metamora issued a call to the physicians of Woodford County to meet in his office for the purpose of organizing a county medical society. At this meeting he was elected President and Dr. Cole of El Paso, Secretary. Annual meetings were well attended and held regularly, drawing physicians from adjoining counties. As there was no active society at that time in LaSalle County, several physicians from both LaSalle and Marshall Counties not only attended the meetings but applied for membership.

In 1872, the Marshall County Medical Society was organized, and it held frequent joint meetings with the Woodford Society. After several such meetings it was decided to organize a larger society, including more counties. At the close of a joint meeting held in Wenona on January 6, 1874, members of the joint society and from surrounding counties formed an association of counties "along the line of and adjacent to the Illinois Central Railroad." At this organization meeting, the following counties were involved: Woodford, Marshall, Putnam, Livingston, LaSalle. Others were added at subsequent meetings. The first officers elected were Dr. Whitmire, President; Dr. Kendall E. Rich, Wenona, Vice-President, and Dr. Cole, Secretary-Treasurer.

A meeting was held in December, 1874, at which time By-Laws were adopted, and the name—North Central Illinois Medical Association—was accepted. Dr. William O. Ensign, a Past-President of the Illinois State Medical Society and for four years a member of the Council, was not only an organizer of this Association but served as its Secretary for a period of fourteen years.

### **Southern Illinois Medical Association**

In the fall of 1874, seven physicians met in the office of Dr. J. I. Hale in Anna, to consider the advisability of developing a medical society in this area to bring about a better understanding between the physicians of southern Illinois and for the advancement of scientific work in this area. These seven were Drs. F. M. Agnew, Makanda; J. I. Hale, Anna; H. C. Hacker, H. Schuchardt and W. C. Lence, Jonesboro; F. S. Dodds, Anna, and W. L. McLane, Dongola. Dr. Hacker, then President of the Union County Medical Society, presided. He was instructed to send a call to the physicians of southern Illinois for a meeting to be held in Jonesboro in January, 1875. On January 20, 1875, the organization meeting was held. Dr. Hacker was chosen as President and Dr. Agnew as Secretary *pro tem*.

Fourteen physicians were present. A committee was appointed by the President to draw up a suitable Constitution and By-Laws and, after their report was heard, the following officers were elected: President, H. C. Hacker; 1st Vice-President, H. Wardner; 2nd Vice-President, John McLeace; Secretary, G. W. Schuchardt; and Treasurer, W. C. Lence.

Meetings were held twice each year until 1901, when the By-Laws were amended to make it an annual meeting of two days. The Association has held meetings each year until more recently it was decided to make it a one-day affair. A list of the officers of this organization contains names of many who have been prominent in the affairs of the Illinois State Medical Society. (*Ed note: The S.I.M.A. recently commemorated its centennial.*)

### Brainard District Medical Society

This society was organized in May, 1877, at Mason City. In 1878, three official delegates were sent to the annual meeting of the State Medical Society: Drs. L. L. Leeds, Lincoln; P. L. Diffenbacker and J. W. Newcomer of Havana. The maximum membership apparently was reached in 1895, when 57 members were enrolled. In 1900, the officers were Drs. F. M. Coppel of Havana, President, and Katherine Miller of Lincoln, Secretary.

### Summary

Records show that there were a number of medical societies in Illinois a century ago which held only a few meetings, in a few instances perhaps only two or three, and then were disbanded. No information is available as to the exact time and place of their organization, officers, lists of members or other pertinent data.

It seems obvious that physicians in Illinois have always been interested in getting together for an interchange of ideas, and to discuss problems in diagnosis and treatment of prevailing ailments. In those days before the exact cause of infectious and contagious diseases was known, physicians, as they do today, had the best interests of their patients uppermost in their thoughts. The attendance at these early meetings was good, even though many hours were spent in going to the meeting and returning home. Occasionally one of these pioneer physicians ventured to predict what might happen to improve medical care and knowledge during the next century.

It is almost uncanny to note how many of the things thus predicted have since actually been developed. Medicine has indeed kept pace with the developments in science, industry and the arts during the past century and will no doubt continue to maintain this record.

Abstrated from *HISTORY OF MEDICINE IN ILLINOIS*, Vol. II.

## PIONEER PHYSICIANS in Illinois

GERSHOM JAYNE, M.D. (1791-1867)/SPRINGFIELD

The story of the early doctors of Springfield is a fascinating one. They were a colorful group and played a vital role in the frontier life of the community. The first cabin in what was to become Springfield was put up by John Kelley in the spring of 1819. Springfield in the 1820's was a cluster of log cabins scattered along Jefferson Street from First to Fourth Streets. There was a small public square set apart for the courthouse. Peter Cartwright who visited Springfield first in 1823, said it contained "a few smoky, hastily-built cabins, and one or two little shanties called 'stores'." The Kickapoo and Potawatomi visited it frequently. There was a large Potawatomi camping ground just west of the present site of Memorial Hospital. To this frontier hamlet, in 1820, came Dr. Gershom Jayne. Jayne was the first doctor in Springfield, and when he settled

here, there were no other doctors north of him in the newly-formed state of Illinois.

### Early Background

Dr. Gershom Jayne was born October 15, 1791, in Orange County, New York. He "received his diploma from the New York medical authorities." There is no registration certificate of Jayne in the County Clerk's Office, since registration of physicians was not required till 1877. Therefore, we do not know if he attended a medical school or if his "diploma" was awarded "on examination." Many physicians were licensed before 1877, on the basis of service with the medical corps in the War of 1812, Mexican War, and Civil War.

Young Jayne served as a surgeon in the War of 1812, and then practiced for a short time in Cayuga County, New York. In 1820, the doctor



came to Illinois by flat-boat down the Ohio River from Pittsburgh. He tarried about six months in Southern Illinois before locating permanently in Springfield. On December 22, 1822, he was married in Sangamon County to Miss Sibyl Slater who had come to Illinois with her parents from Massachusetts in 1818.

Doctor Jayne's first home was a double log cabin "in which he kept travelers overnight." It was situated on the north side of Jefferson Street between Second and Third Streets. Later he built a large home on the northwest corner of Fourth and Jefferson Streets where he lived the rest of his life.

### Practice Techniques

The doctor's practice was a large one and reports state he traveled by horseback and sulky over an area within a fifty mile radius of Springfield. It was usual for a doctor to make rounds over a wide area, staying overnight in his patients' homes, and frequently away for one or two weeks at a time.

We know little of the medicine practiced by Jayne but assume that he used calomel, blue mass, castor oil, and bleeding as was the fashion of his day. Jayne lived at a time when the teachings of Benjamin Rush were still expounded as gospel. Rush, following his experiences with the terrible yellow fever epidemic of 1793 in Philadelphia, believed that fevers were caused by hyperexcitability of the blood vessels and could be cured only by the most drastic purging and bleeding. Jayne, no doubt, had good reason to question the teachings of Rush, when cholera struck Springfield in 1833 and again in 1849.

### Community Activities

Dr. Gershom Jayne took a very active part in community affairs as well as practicing medicine. In 1826, Jayne was the foreman of the jury in the first murder trial in Sangamon County, when Nathaniel Van Noy was found guilty of murdering his wife in a drunken rage. Doctor Jayne may well have been in the back of the very large crowd that gathered just north of the present statehouse site to watch the hanging of Van Noy.

In 1827, Jayne served as surgeon to a company of soldiers from Springfield in the "Winnebago War." After many difficulties, the chief being the inability to find any Indians, the company was disbanded and straggled home. The same year, Jayne was appointed one of the commissioners to construct the first State Penitentiary (at Al-

ton), and then was appointed one of the first three commissioners of the Illinois and Michigan Canal. He was in politics, early a Whig and later a Republican.

Early in 1831, Jayne was named to a citizens committee to raise funds to assist in bringing the steamboat "Talisman" up the Sangamon River from Beardstown to Springfield. The following year Jayne was a member of the first Springfield Board of Health.

In 1850, Doctor Jayne was one of "twenty-nine forward-looking, progressive physicians" who gathered in the old statehouse to organize the Illinois State Medical Society.

Doctor Jayne never united with any church though he was reported to have made heavy contributions to the First Presbyterian Church and was a close friend of Dr. John G. Bergin, the first minister of Springfield. Doctor Jayne induced Doctor Bergin to read six lectures on intemperance prepared by Dr. Lyman Beecher before his congregation and is credited with forming the first temperance society in Sangamon County.

"He was a great reader, and possessed a retentive memory. Poetry was his especial delight, and he knew how to quote it readily and with effect. The great aim and object of his life was in the line of his chosen profession, and to that he gave the enthusiasm and energy of an acute mind and a sound body—his practice was large and reasonably lucrative—his career was eminently successful."

### Family

Doctor and Mrs. Jayne were the parents of four children: 1) Julia, born June 1, 1823, was bridesmaid to Mrs. Abraham Lincoln, and later married U.S. Senator Lyman Trumbull. 2) William, born Oct. 8, 1826, graduated from Illinois College of Jacksonville, and the medical department of Missouri State University. In addition to being a doctor, he was Mayor of Springfield in 1859, State Senator in 1860, and appointed Territorial Governor of Dakota in 1861. 3) Henry, born in 1837, aide-de-camp in the Union Army, attended medical lectures in 1865 at the University of Michigan, and located in Taylorville for the practice of medicine in 1866. 4) Mary Ellen, never married and lived with her parents.

Gershom Jayne died April 17, 1867, and is buried on a beautiful knoll in Oak Ridge Cemetery just north of Lincoln's tomb. A few yards

*(Continued on page 86)*



# Congenital Heart Disease in Families

BY B. AGARWALA, M.D., RITA AGARWALA, M.D. AND T. BAFFES, M.D./CHICAGO

*Three families with congenital heart defects are presented. The association of mental retardation in all three affected members of the family with pulmonic valvular stenosis is emphasized. The risk of having children born with congenital heart defects in parents who were born with malformation of the heart is discussed. Finally the importance of genetic counseling with the knowledge of recent advancement of cardiac surgical facilities is pointed out.*

Structural anomalies of the embryo play a leading role in mortality during the first trimester of pregnancy. Only certain anomalies are compatible with extra-uterine life. The fetus must adjust to the profound extra-uterine physiologic changes that take place immediately at birth. Many factors are responsible for these malformations during embryogenesis, e.g. mechanical, chemical, nutrition, infection, chromosomal anomalies, familial, etc. It is outside the scope of this article to enumerate all of them. However, we would like to emphasize the role of familial factors responsible for the intra-uterine malformation of the heart.

Congenital heart defect is one of the major and serious birth defects. Recent studies relating to the incidence of congenital heart disease suggested that the overall incidence is approximately eight per thousand live births.<sup>1</sup> The etiology of the congenital malformation is unknown. At present, it is known that genetic factors, chromosomal abnormalities and extra-uterine environmental factors are responsible for the inborn defects of the heart to a certain extent. However,

the major cause of this defect is still a mystery.<sup>2</sup>

Recently the familial incidence of recurrence of congenital heart disease has been emphasized. It is very important to draw attention to the familial form of congenital heart disease in order to gain more knowledge about its inheritance.

We have recently studied five children of three unrelated families with severe congenital heart defects. Mothers of the two families and their children had congenital heart defects. Our purpose is to present these three unfortunate families with multiple incidence of the same kind of congenital heart defects. Family I with severe valvular pulmonic stenosis, in mother, daughter and son; family II with ventricular septal defect in mother and daughter, and family III with valvular aortic stenosis in daughter and son. We also draw attention to the fact that all three subjects with severe valvular pulmonic stenosis are mentally retarded. This association of familial valvular pulmonic stenosis with mental retardation is a new syndrome which may possibly need future recognition.

## Case Histories

### Family I—Pulmonary Valvular Stenosis

#### A. Mother's History

This 28-year-old black female was born following a normal full term pregnancy and delivery. Her birth weight was 3400 gms. A heart murmur was first noted at 8 years of age when she had bronchitis. She was completely asymptomatic at the time of catheterization and surgery.

Physical examination prior to cardiac catheterization revealed a thin, undernourished, slightly mentally retarded child, not in acute distress. There was no evidence of edema, clubbing or cyanosis. Peripheral pulses were felt strong in all four extremities. Abdominal examination was normal and lungs were clear on auscultation. On examination of the heart, a precordial maximal impulse at the 4th left intercostal space on mid-clavicular line was revealed. There was no para-

BROJENDRA AGARWALA, M.D., is an Assistant Professor of Pediatrics, Rush Medical School and Attending Physician in Pediatrics at Mt. Sinai Hospital where he specializes in Pediatric Cardiology. He is a Fellow of the American Academy of Pediatrics and has published several articles.



RITA AGARWALA, M.D., is a first year resident in Radiology at Mt. Sinai Hospital. She is interested in doing research work in Nuclear Medicine.

THOMAS BAFFES, M.D., is Chairman of the Department of Surgery at Mt. Sinai Hospital and an Attending Surgeon at several other hospitals. He is also a Lecturer at DePaul University School of Law. Dr. Baffes has published numerous articles and is a member of many professional organizations.

sternal heave and a prominent systolic thrill was palpable best at the 2nd left intercostal space along the sternal border. On auscultation a grade 4/6 ejection systolic murmur was heard best at the upper left sternal border. The diastole was clear. Her first heart sound was normal with diminished pulmonic component of the second heart sound. The chest X-ray was normal and the electrocardiogram showed right axis deviation with right ventricular hypertrophy.

Cardiac catheterization in 1951 confirmed the diagnosis of severe pulmonic valvular stenosis (see Table 1). Pulmonary valvulotomy was done in 1955. At present, she is a mother of four children and doing well.

space along the sternal border with wide radiation over the precordium. Diastole remained clear. Chest X-ray showed normal heart size with dilatation of the main pulmonary artery and normal pulmonary vasculature. Severe right axis deviation with right ventricular hypertrophy was present in the electrocardiogram. Cardiac catheterization at 14 months confirmed the diagnosis of severe pulmonic stenosis (Table 1). Pulmonary valvulotomy was done with an uncomplicated post-operative period.

### C. Daughter's History

A three-year-old black female was the product of a normal full-term pregnancy and delivery.

**Table 1**  
**Family I with Pulmonic Valvular Stenosis**

	Mother		Son		Daughter	
	O <sub>2</sub> Vol. (%)	Pressure (mm Hg)	O <sub>2</sub> Vol. (%)	Pressure (mm Hg)	O <sub>2</sub> Vol. (%)	Pressure (mm Hg)
IVC	13.68	—	—	—	10.21	
SVC	10.00		14.18		9.40	
RA	12.59	a-5 v-3	14.88	a-9 <sub>m-5</sub> V-6	9.76	a-13 <sub>m-9</sub> v-11
RV	12.20	85/0	13.00	95/7	10.04	103/11
MPA	12.30	25/18	14.55	23/12 m-17		16/9 m-11
LV						85/9
Asc. aorta		100/60	18.97 (97.8% saturation)	105/70		
Brach. artery	17.6 (99% saturation)					
Femoral artery					14.80 (98% saturation)	

### B. Son's History

A four-year-old, black male was born after 7 months gestation. His birth weight was 1700 gms. A heart murmur was noted at birth. He was slightly slow in growth and mental development, but remained asymptomatic.

Physical examination at 14 months revealed a thin, active boy with slight mental retardation in no acute distress. He was 9.4 kilograms in weight and 66 cm in height. On palpation the abdomen was soft, not tender, and had no organomegally. Both lungs were clear on auscultation and the peripheral pulses were normal and equal in both upper and lower extremities. On cardiac examination, the precordial maximal impulse was on the 4th left intercostal space on the mid-clavicular line with a systolic thrill along the upper left sternal border. There was no palpable heave. First heart sound was normal with a widely split second heart sound and diminished pulmonic component. A grade 4/6 ejection systolic murmur was noted best at the second left intercostal

Her birth weight was 3055 gms. A heart murmur was noted soon after birth, otherwise the neonatal period was normal. Growth and development was slightly slow, but she remained asymptomatic.

On physical examination she was found to be slightly slow in mental and physical development. Her weight was 11.5 Kg with a height of 90 cm. Vital signs were as follows: heart rate 82/minute, respiratory rate 22/minute and the right arm blood pressure 100/75 mm Hg. On cardiac examination the precordial maximal impulse was on the 4th left intercostal space on the mid-clavicular line. A faint parasternal heave and a prominent cystolic thrill at the upper left sternal border were noted. Her first heart sound was normal with a single second heart sound. A grade 4-5/6 ejection systolic murmur was best heard at the upper left sternal border with wide radiation all over the precordium. The diastolic period was clear and the rest of the physical examination was within normal limits. Her chest

X-ray demonstrated a normal size heart with mildly prominent main pulmonary artery and normal pulmonary vasculature. There was evidence of marked right axis deviation and right ventricular hypertrophy with upright T wave all over the precordium. The diagnosis of severe pulmonic valvular stenosis was confirmed by cardiac catheterization (Table 1). Pulmonic valvulotomy was done with an uncomplicated post-operative period.

## Family II—Aortic Valvular Stenosis

### A. Son's History

A five-year-old, white male was born following normal full term pregnancy and delivery. His birth weight was 2700 gms. A heart murmur was first noted at one year of age on routine examination. His growth and development were normal. He was completely asymptomatic. One uncle was born with a 'heart problem'.

Physical examination revealed a well developed, well nourished, active and intelligent boy in no distress. He was 105 cm in height and 16.4 Kg in weight. His heart rate was 88/min., respiratory rate 20/min., with both a right and left arm blood pressure of 110/70 mm Hg. There was no evidence of edema, cyanosis or clubbing, peripheral pulses were symmetrical in both upper and lower extremities. Cardiac examination revealed precordial maximal impulse to be on the 4th left intercostal space inside the mid-clavicular line. There was no heave, a faint systolic thrill was palpable at right base. His first heart sound was normal with a narrowly split second heart sound. A grade 3/6 ejection systolic murmur was heard best over the right second in-

tercostal space with radiation to the neck. The diastolic period was clear. An ejection systolic click was heard also at the right second intercostal space. The rest of the physical examination was normal. His chest X-ray showed a normal size heart with prominent ascending aorta. The electrocardiogram was compatible with left ventricular hypertrophy by voltage criteria. T wave was normal for age. Cardiac catheterization confirmed the diagnosis of a moderate degree of bicuspid aortic valvular stenosis (Table 2). He does not need any surgery at the present time.

### B. Daughter's History

A two-year-old, white female was born following a normal full-term pregnancy, with a birth weight of 2800 gms. A heart murmur was first noted at 1 year of age on routine physical examination. She remained asymptomatic throughout her life.

On physical examination she was a thin, intelligent girl in no distress. Her body weight was 12.5 Kg and her height was 80 cm. The heart rate was 84/min., respiratory rate 22/min., and the blood pressure was 110/60 mm Hg in both arms. There was no evidence of edema, cyanosis or clubbing and the peripheral pulses were normal. On cardiac examination the precordial maximal impulse was at the 4th left intercostal space on the mid-clavicular line. There was no heave. A systolic thrill was palpable at both the right and left second intercostal spaces. The first heart sound was normal with a narrowly split second sound. A grade 3/6 ejection systolic murmur was best heard at the right base with some radiation to the neck vessels. The diastolic period was clear. An ejection systolic click was noted at the

Table 2  
Family II with Aortic Valvular Stenosis

	Daughter		Son	
	O <sub>2</sub> Saturation (%)	Pressure (mm Hg)	O <sub>2</sub> Saturation (%)	Pressure (mm Hg)
IVC	87.2	—	82.0	—
SVC	76.8	—	74.2	—
RA	82.0	a-5 <sub>m-2</sub> v-3	75.0	a-5 <sub>m-1</sub> v-4
RV	76.5	26/4	76.4	19/3
MPA	76.8	20/9 m-13	75.4	18/6 m-11
RPA	79.6	23/9 m-13	75.3	—
RPA—Wedge	—	a-9 <sub>m-8</sub> v-12	—	—
LV	—	164/8	—	106/60
Asc. aorta	97.2	91/63 m-75	96.2	90/62 m-78
Cardiac index	4.5 liter		4.1 liter	—
Aortic valve area index	0.55 cm <sup>2</sup>		1.4 cm <sup>2</sup>	—



right second intercostal space along the sternal border. The heart size was normal in the chest X-ray with evidence of dilatation of the ascending aorta. Her electrocardiogram suggested evidence of left ventricular hypertrophy with some S-T and T changes. Cardiac catheterization confirmed the diagnosis of severe bicuspid aortic valvular stenosis (Table 2). An aortic valvulotomy was done and the post-operative course was uncomplicated.

### **Family III—Ventricular Septal Defect**

#### *A. Mother's History*

This 42-year-old black female had been born with a heart murmur. She was asymptomatic and had undergone cardiac catheterization in 1958, when the diagnosis of ventricular septal defect was made in another hospital. (Table 3) Surgical closure of the defect was suggested but she refused the operation. At present she is asymptomatic and does not see any cardiologist for followup.

On physical examination she was well developed, well nourished and in no acute distress. Her vital signs were normal. There was no evidence of cyanosis, edema or clubbing. On examination of the heart, the precordial maximal impulse was in the 6th left intercostal space with increased left ventricular impulse. A systolic thrill was palpable along the left lower sternal border. Her first and second heart sounds were normal. A gr. 4/6 holosystolic murmur was best heard along the left lower sternal border and a gr. 1/6 mid-diastolic rumble was noted at apex. The rest of the physical examination was within normal limits.

#### *B. Daughter's History*

A nine-year-old black female was born following normal full-term pregnancy and delivery. A heart murmur was first noted at 4 years of age on routine physical examination. She underwent cardiac catheterization in 1968, followed by open heart surgery in 1969, for closure of her large ventricular septal defect. During the post-operative period a loud heart murmur was noted, however, her post-operative course was normal. Since then she is being maintained on Digoxin and is asymptomatic at present.

On physical examination she was a well developed, well nourished intelligent young girl in no acute distress. Her body weight and height were 35 Kg and 100 cm respectively. Vital signs were normal. There was no evidence of edema, clubbing or cyanosis. Peripheral pulses were nor-

mal. On cardiac examination the precordial maximal impulse was at the left 6th intercostal space with an apical heave. A systolic thrill was noted along the lower left sternal border. The first and second heart sounds were normal. A grade 4-5/6 holosystolic murmur was heard best at the left lower sternal border with wide radiation all over the precordium. A grade 2/6 mid-diastolic rumble was heard at apex. The rest of the physical findings were within normal limits.

Her chest X-ray showed increased heart size with left ventricular enlargement and a prominent main pulmonary artery. The pulmonary vasculature was increased. The electrocardiogram was interpreted as right axis deviation (+100 degrees mean QRS axis) with biatrial hypertrophy, left ventricular hypertrophy and right bundle branch block.

The second cardiac catheterization (Table 3) revealed evidence of a moderate size ventricular septal defect with a left to right shunt and mild degree of pulmonary hypertension.

### **Discussion**

The etiology of the congenital heart defects is multifactorial. The exact mode of inheritance or the incidence of the familial recurrence of congenital heart defects is not clear. Large prospective studies in the future may answer some of the questions. The vast literature which has accumulated over the last twenty years tends to divide itself into two major categories: (1) familial recurrence and (2) environmental factors during embryogenesis. It is not possible to discuss here all the etiologic factors responsible for the congenital cardiac malformations.

It is well known that the frequency of congenital heart disease is higher in relatives of patients than in the general population.<sup>3</sup> In the past, families with aortic stenosis, ventricular septal defect and pulmonic stenosis have been described in the literature. However, a question has been raised about whether there is concordance for the congenital heart anomalies in the same family. Our cases are unique examples of the concordance of congenital heart anomalies in each family.

Pulmonic stenosis including infundibular stenosis is a common anomaly of the heart, comprising about 6.9% of all congenital heart defects at birth.<sup>4</sup>

The familial occurrence of pulmonic stenosis is not common.<sup>5,6</sup> A pair of twins, both having pulmonic stenosis, was described in the literature.<sup>2</sup> Pulmonic stenosis has been described with

**Table 3**  
**Family III with Ventricular Septal Defect**

	Daughter		Mother	
	O <sub>2</sub> Satura- tion (%)	Pressure (mm Hg)	O <sub>2</sub> Satura- tion (%)	Pressure (mm Hg)
IVC	71.0	—	70.0	—
SVC	69.6	—	69.5	—
RA	70.8	a-8 <sub>m-6</sub> v-7	70.6	a-6 <sub>m-5</sub> v-4
RV	84.0	43/4	83.4	25/6
MPA	—	46/16 m-26	83.3	24/12 m-15
RPA	79.8	—	82.2	22/12 m-16
LV	95.4	97/5	95.0	110/7
Asc. aorta	96.2	97/62 m-75	95.1	110/65 m-75
Systemic Blood Flow Index	— 2.8 Liter			
Pulmonic Blood Flow Index	— 4.9 Liter			
Pulmonary Vas- cular resis- tance	— 4 Units			
Systemic Vas- cular resis- tance	— 23 Units			

certain syndromes like Noonan syndrome, Trisomy-18, etc. Peripheral pulmonic stenosis from congenital rubella syndrome with other cardiac and extra-cardiac malformations is a known entity. Kahler et al.<sup>7</sup> described 3 families with supravulvar aortic and pulmonic stenosis. However, all these entities are different than that of our patients described in this article.

Three patients (mother, son and daughter) described in our presentation do not fit into any known syndrome that has been described in the literature. All three patients are mentally retarded and all of them had severe pulmonic valvular stenosis requiring valvulotomy.

Congenital aortic valvular stenosis is a relatively common anomaly. Nadas and Keith et al.<sup>8,9</sup> estimated its incidence to be 2 to 6%. However, this figure may be misleading because of the presence of a bicuspid aortic valve which may be undetected at birth due to the lack of any murmur. This may become stenotic in the adult life. The most common subvalvular aortic stenosis is idiopathic hypertrophic subaortic stenosis. Braunwald et al.<sup>10</sup> described the high incidence of its recurrence in the family.

Supravulvar aortic stenosis may occur in association with idiopathic infantile hypercolcemia, a disease related to deranged vitamin D metabolism.<sup>11</sup> This disorder is in coexistence with mental retardation and 'Elfin facis,' as well as many other skeletal, dental and peripheral vascular anomalies. However, congenital supravul-

var aortic stenosis associated with peripheral pulmonic stenosis runs in the family and the malformation is not related to Vitamin D metabolism during intrauterine life.

Ventricular septal defect is the most common type of congenital heart defect. The incidence of ventricular septal defect among all the congenital heart diseases is approximately 30%. Nora et al.<sup>12</sup> in their study of offspring of 308 adult patients with congenital heart disease (most of them were surgically corrected) found that for ventricular septal defect, 3.7% of the children were similarly affected. This is 21 times the estimated population frequency.

### Conclusion

The occurrence of congenital heart defects in offspring of patients with congenital cardiac malformations are significantly higher than that of the population frequency. This prompts the question of whether recent advances in knowledge, technical help for diagnosis and surgical therapeutic improvement will gradually increase the prevalence of congenital heart defects in the future. However, it is not known at present whether the patients with congenital heart defects are less fertile or not. The patient who has had surgical repair of his heart and is therefore not physically handicapped, is not marrying as early or frequently as the general population. This may decrease the chance of transmitting the disease to the general population.<sup>12</sup>

Finally, it is very important to realize the need for genetic counseling in these families. A family with congenital heart defects does have a higher risk of having another child born with a similar or different type of cardiac malformation. In advising these parents about planned parenthood, one has to consider the emotional background of the affected family, and how much they want to have one child even with the known risk. Thorough knowledge of the therapeutic goal in the management of congenital heart defects at the present time and its future progress are helpful in counseling these groups of parents with congenital cardiac malformation. ◀

#### References

A list of references for "Congenital Heart Disease in Families" may be obtained by writing *IMJ*, 55 E. Monroe, Suite 3510, Chicago 60603.

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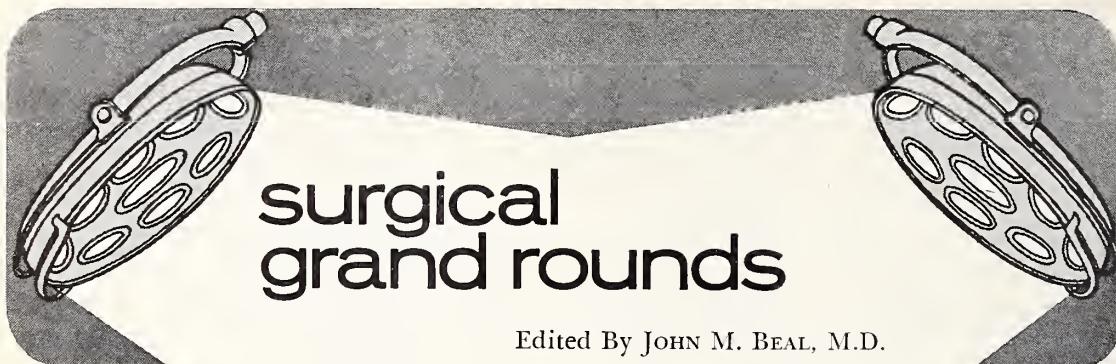
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## By-Pass Operation for Obesity

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Lakeside Veterans Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 19, 1975.*

**Dr. Stanley Carson:** A 52-year-old woman was admitted to the Northwestern Memorial Hospital in June, 1975, for elective surgical treatment of obesity. At the time of admission, she weighed 390 lbs. (twice her maximum ideal weight). The patient said that she had always been "pudgy," but stated that her massive weight gain began after an abdominal hysterectomy and oophorectomy in 1945, when she had the onset of eating frequently. The patient had maintained a weight above 300 lbs. for over 20 years before this admission.

Complications that have been related to her obesity include a history of hypertension for more than ten years, a history of elevated blood sugar levels, deep venous insufficiency which had required two admissions to hospital during the past five years for control of stasis ulcers. She was dyspneic and required a rest after climbing two steps. In addition, her knees were painful and she had been told that she had arthritis. Attempts at weight control has been largely unsuccessful.

### Pre-operative Examination

Physical examination revealed a markedly obese white woman with multiple areas of intertriginous dermatitis, venous stasis changes of her lower extremities. Routine laboratory studies included normal blood counts, urinalysis, and survey blood chemistries. Her cardiogram and chest X-ray were reported to be within normal limits. Thyroid function tests ( $T_3$ ,  $T_4$ , and FTI) were

unremarkable. Urinary corticosteroid excretion was within normal limits. A psychiatric evaluation was obtained and did not contribute to the patient's problem. Cholecystography revealed faint visualization of the gallbladder. Serum electrophoresis revealed a hyperbeta lipoproteinemia, type 2B which is associated with accelerated atherosclerosis. Tests for gastrointestinal malabsorption were negative. Flow studies were performed on the lower extremities and thrombosis of the left popliteal vein was found. The patient was unable to perform a stress electrocardiogram because she could not walk well enough.

Pulmonary function tests demonstrated a moderately severe obstruction. Blood gas determinations disclosed a slight hypoxemia without hypercarbia. Preoperative preparation included skin care, a carefully monitored low calorie diet, and respiratory therapy.

On July 28, with her weight at 354 lbs, the patient was taken to the operating room where jejunoileal by-pass, cholecystectomy, and a liver biopsy were undertaken.

### Post-operative Course

Postoperatively, the patient was maintained on a ventilator for two days and received prophylactic subcutaneous heparin until she was ambulating well.

Oral intake was begun on the fourth postoperative day and progressed to a general diet by the eighth day. Hypokalemia was controlled with

potassium supplements and she received calcium carbonate to prevent hyperoxaluria. Fitted stockings were provided because of her venous insufficiency. She was discharged two weeks after operation on a general diet. (The patient enters)

### Interview

**Dr. Stuart Poticha:** "I am going to ask you some questions which relate to your operation. How long had you been overweight?"

**Patient:** "I'm 52 years old and have been fat since I was about 21 years old."

**Dr. Poticha:** "What made you decide to have this operation?"

**Patient:** "I was tired of being fat. I went to a clinic and was told about the operation."

**Dr. Poticha:** "What were you able to do before your operation?"

**Patient:** "I couldn't do anything; I just sat on my 'rear end' for about three years. Someone had to do everything for me. I could not go to the store to shop."

**Dr. Poticha:** How do you feel since your operation—do you feel weak, just the same, or different?"

**Patient:** "I feel stronger and can do some things at home."

**Dr. Poticha:** "How about diarrhea?"

**Patient:** "That's pretty rough—sometimes more, sometimes less. I had three bowel movements today, but I didn't eat very much." (Patient leaves)

### Discussion

**Dr. Stuart Poticha:** I thought we might begin our discussion by considering whether or not surgical intervention is ever justified in obesity. First, let us consider the quality of life in the massively obese. It is apparent, not only from what this patient said, but also from her appearance that this woman had very little to look forward to in life. She couldn't walk up stairs, and she couldn't go out of the house. For all intents and purposes, she was an invalid because of her obesity. Secondly, her massive obesity constituted a serious threat to her life. The Metropolitan Life Insurance Company states that there is a 10 to 20% increase in mortality rate in patients who are more than 20% over their ideal weight and the mortality increases further in direct proportion to their weight. Cardiovascular disease is increased by 150%, diabetes is 400% increased, and cirrhosis is 250% increased. The Framington study, which is often quoted in this regard, showed that men overweight at 45 years had

double the incidence of new cases of arteriosclerotic heart disease.

Lastly, what nonsurgical measures are available to deal with this problem and what are the results? Stirkland and McClaren described 100 patients treated by diet, of whom two were able to maintain a 20 lb. weight loss for two years. Trelson and McCann reported 180 patients, 5% of whom maintained some weight loss for three years. Glennan reported 6% of patients maintained a 20 lb. weight loss for two years; while Feinstein reported that 2% of patients maintained a weight loss for five years. In summary, most studies reveal that with a carefully managed diet, 10% to 40% of patients will have lost weight at the end of the first year, but only 1% to 13% will maintain some weight loss for a period of five years. These studies indicate that for the majority of massively obese patients, medical therapy fails.

### Criteria for Operation

Because of these poor results, an operation for the purpose of weight loss was first devised by Payne and DeWin in 1963. Since that time, many patients have undergone intestinal by-pass operations for obesity and a group of criteria for choosing patients for this type of surgery has evolved. The criteria for operation at Northwestern are listed in Table I.

Since 1972, we have interviewed 17 patients for intestinal by-pass. Ten patients failed to fulfill one or more of our criteria and were encouraged to pursue medical management by diet.

### Results

Seven patients were admitted to the hospital, two of whom refused to complete this work-up and were discharged without operation. Five patients have undergone an intestinal by-pass operation, in which 14 inches of jejunum were anastomosed to four inches of terminal ileum. The results are shown in Table II. All the patients have had good results except patient AH. This patient's result is classified as 'fair' because although her weight reduction has been excellent, she is still incapacitated by diarrhea to the extent of not being able to return to her former job as a court reporter. The other patients are all working and require only occasional doses of Lomotil to control episodes of diarrhea which are precipitated by dietary indiscretions.

There have been two complications. The first patient, BB, developed cholelithiasis three years



after her by-pass, requiring elective cholecystectomy. Since 1972, all patients have undergone cholecystectomy at the time of the intestinal by-pass. The fourth patient, SK, developed a small bowel obstruction in the immediate postoperative period and this necessitated a second operation.

Several serious late complications have been reported in the literature. The following case histories illustrate two of these complications.

### Case Histories Representing Complications

**Dr. James Kliefoth:** A 46-year-old white woman had an ileojejunal by-pass operation for obesity in April, 1972, and was recently admitted for construction of an arteriovenous fistula for chronic renal failure. The patient was first operated on in April, 1972, at which time her weight was 270 lbs. Her serum creatinine level at that time was 1.07 mg. % and her blood urea nitrogen level was normal. Since this operation, she has had multiple admissions for chronic bronchitis, for generalized malaise, and for hepatitis. Hepatitis presented six months following operation. Her serum creatinine level gradually increased until December, 1974, when her creatinine level was 2.82 and BUN was 33 mg.%. In April, 1974, she noticed the onset of peripheral edema and shortness of breath and was admitted to the hospital. At this time, her creatinine was 5.68, BUN was 58 mg.%. An intravenous pyelogram revealed calcifications in both kidneys, which were small. At this time, continuity of the bowel was re-established. However, her renal failure has progressed so that now her creatinine has reached 14, with BUN 126 mg.%. Hemodialysis is now required.

**Dr. John Beal:** Were these operations performed elsewhere?

**Dr. James Kliefoth:** The original ileal by-pass was performed elsewhere, but the reconstruction was performed here.

### Possible Renal Failure

**Dr. John Beal:** Dr. Frank Krumlovsky will discuss renal failure in association with by-pass operations for obesity.

**Dr. Frank Krumlovsky:** This patient showed rather classic nephrocalcinosis. Not only were there grossly visible calcium deposits in her kidneys, but also the preliminary film looked much the same as the nephrograph phase. The renal shadows were hyperopacified, representing, pre-

sumably, microscopic intrarenal calcifications.

I would like to say a word about nephrocalcinosis in general before discussing the specific problem related to hyperoxaluria that this patient illustrates. Nephrocalcinosis is usually seen in hypercalcemic conditions—hyperparathyroidism, Vitamin D intoxication, metastatic carcinoma, multiple myeloma, sarcoid, hyperthyroidism, etc. and is characterized primarily by interstitial deposition of calcium in the kidney. This results in the clinical picture of interstitial nephritis, with round cell infiltration progressing to interstitial fibrosis. The problem, as was the case with this patient, is that this process may not be reversible with removal of the etiologic factor, because once the interstitial inflammatory response has begun, the process may be self-perpetuating. When her by-pass was taken down, she still had adequate renal function to remain off dialysis, but her renal failure continued to progress rapidly over the next four or five months until she did require dialysis.

There appears to be an increased incidence of renal stone disease associated with gastrointestinal disease. The increased incidence of renal stones associated with ulcerative colitis, as well as with regional enteritis, is reasonably well documented, both in patients who are managed medically as well as those who have ileostomies. A report of one large series of over 450 patients with ulcerative colitis showed a 4% incidence of renal stones in patients managed medically and an 8% incidence in patients managed surgically. This high incidence was thought to be due to two primary reasons. First, the patients tend to be chronically dehydrated and have concentrated urine, which of course, predisposes to stone formation. Secondly, their urine tends to be acid, especially the ileostomy patients. As you probably know, an acid urine results in decreased solubility of uric acid. Now, you say, what does uric acid have to do with calcium stones? It has been recently quite well documented by Dr. Fred Cole at Michael Reese Hospital that a uric acid nidus probably represents the beginning of many calcium stones. Therefore, a situation such as acid urine which predisposes to decreased urate solubility may result in an increased incidence of calcium stones.

### Hyperoxaluria

Finally, to address the problem of this patient—the etiology of her nephrocalcinosis and renal failure was felt to be hyperoxaluria. Hyperoxaluria can be classified as congenital and ac-



quired. I will say little about congenital; there are a couple of rare enzyme abnormalities that produce this condition and usually lead to renal failure at a relatively early age. Acquired hyperoxaluria is secondary to four or five major circumstances. One is ethylene glycol ingestion—ethylene glycol is metabolized to oxalate—the anti-freeze drinkers. Another is excessive ascorbic acid intake; ascorbic acid is also metabolized to oxalate and we may be seeing an increased incidence of this problem with the vitamin C craze for preventing colds. Pyridoxine deficiency can cause this problem, because pyridoxine is required for oxalate metabolism. The most interesting, perhaps, is so called rhubarb gluttony; people who eat a lot of rhubarb over a period of time can develop hyperoxaluria and renal stones on that basis. Lastly, the area that concerns us most here, virtually any disease of the small bowel, especially the distal ileum, seems to be capable of producing hyperoxaluria. This has been seen in people with ileostomies, with ileal resection, with by-pass procedures such as described today, and in patients with sprue.

There have been two major mechanisms postulated to explain the hyperoxaluria associated with ileal disease. One postulates that the ileal disease results in decreased absorption of conjugated bile salts in the distal ileum, which results in an increased delivery of bile salts to the colon. The colonic bacteria then are postulated to split off glycine from the bile salts and convert it to glyoxylate, which is then absorbed, passes through the liver, and is converted to oxalate. This theory has been somewhat rejected in recent years, because of evidence that if one administers bile salt labelled glycine to these patients, very little appears to turn up as oxalate.

The second theory, which is more widely accepted currently, is that these patients simply over absorb oxalate. Whatever oxalate is ingested orally in their diet is over absorbed, resulting in hyperoxaluria. The mechanism for this is thought to be that the fat malabsorption associated with their steatorrhea results in binding of intraluminal calcium with fat and the formation of soaps, making less intraluminal calcium available for binding with oxalate. This in turn results in free oxalate in the intestinal lumen, facilitating oxalate absorption and tending to produce hyperoxaluria.

What can be done about this? It has been demonstrated that simply giving these people a diet low in oxalate tends to partially eliminate the problem and may reduce their urinary oxalate to

normal. Cholestyramine has been used in this situation to directly bind oxalate in the intestine and may also be useful. In this patient, calcium is being administered, with the intent of binding oxalate in the gastrointestinal tract. The solution I've just recounted has been widely published since 1972 or 1973. When she was initially seen in December, 1974, with an elevated BUN (33 mg. %), and had experienced the onset of renal insufficiency, the flat plate of her kidneys already demonstrated evidence of nephrocalcinosis. It is conceivable that if this problem had been recognized and her by-pass taken down at that time, her renal failure might not have progressed as it did.

### Second Case History

**Dr. Stanley Carson:** The next patient is a 33-year-old white woman who is three years post-jejunoileal by-pass. This patient was admitted three weeks ago for elective cholecystectomy. After her by-pass operation, she had lost from 150 to 160 lbs. and had maintained her weight at about 190 for one and one-half years. After her obesity operation, the patient complained of frequent abdominal symptoms related to eating, which included gaseous distress and distension, as well as mild diarrhea. After a particularly heavy meal this year, she had an episode of epigastric fullness and discomfort for which she saw her doctor. A cholecystogram was performed and multiple gallstones were found. Physical examination was essentially normal except for her obesity and her operative scar. The laboratory studies including chest X-ray and electrocardiogram were unremarkable. A cholecystectomy was performed and multiple stones were found in a chronically inflamed gallbladder. She had a normal operative cholangiogram at that time. Her postoperative course was uncomplicated.

### Gallstones in the Obese Patient

**Dr. John Beal:** Dr. Robert Craig will discuss gallstones in the obese patient.

**Dr. Robert Craig:** To understand the metabolic problems of ileal by-pass, we have to know something about bile salt metabolism. Bile salts have a hydrophilic and a hydrophobic side, ideally suited for solubilizing lipids. Bile salts form mixed micelles into fats and fatty acids. The fat soluble vitamins are contained within this micelle. The micelle then brings the fats to the intestinal border, where they are absorbed. The function, then, of bile salts is to promote solubilization of the fats and the fat soluble vitamins.

**Table 1**  
**Criteria for Patient Selection**

- A. Minimum of 100 lbs. over ideal weight for at least five years
- B. Evidence of failure to respond to dietary management
- C. Absence of correctable endocrinopathy
- D. Absence of significant systemic disease
- E. Patients who are willing to undergo intensive workup and complete follow-up
- F. Evaluation and approval by gastroenterology

**Preoperative Evaluation**

- A. Complete history and physical examination
- B. Cardiac evaluation
  - 1. EKG
  - 2. Masters test
- C. Pulmonary evaluation
  - 1. Arterial blood gases
  - 2. Pulmonary function tests (respiratory rate, tidal volume, forced vital capacity)
  - 3. Chest X-ray
- D. Gastrointestinal evaluation
  - 1. Upper GI and small bowel series
  - 2. Barium enema
  - 3. Cholecystogram
- E. Endocrine evaluation
  - 1. T<sub>3</sub>, T<sub>4</sub>, PBI
  - 2. 24-hour urinary 17 ketosteroids and 17 ketogenic steroids
- F. Metabolic evaluation
  - 1. Cholesterol, free fatty acids, serum triglycerides, lipoproteins, serum carotene, total amino acids
  - 2. Glucose tolerance test, Shilling test, d-xylose tolerance test
- G. Hematologic evaluation and blood chemistries
  - 1. CBC and differential and red rate
  - 2. BUN and creatinine
  - 3. Na, K Cl, Ca, Mg, P, Fe
  - 4. Protein electrophoresis
- H. Liver function
  - 1. SGOT, SGPT, LDH, Alk Phos
  - 2. Serum bilirubin
  - 3. Prothrombin time
- I. Stool examination
  - 1. Fat

Patients with ileal by-passes have a bile salt wasting syndrome, where the bile salts are no longer present because the bile salts are poured into the colon. There is insufficient terminal ileum for the active absorption of the bile salts. Thus, there is a bile salt deficient syndrome and most of the metabolic complications of the ileal by-pass are the result of this.

Therefore, malabsorption is the first complication of the ileal by-pass, and is a desired result because weight loss results. Malabsorption is due to: 1) diminished bile salts and 2) diminished small intestine surface area for absorption of fat. In particular, fat soluble vitamins are malabsorbed and this complication must be considered in patients with ileal by-pass.

In addition to malabsorption, the rapid entry of bile salts into the colon causes a cholorrhetic

diarrhea. In addition to the cholorrhetic diarrhea, patients with this problem have diarrhea induced by the malabsorbed fat, so called steatorrhetic diarrhea. Diarrhea, then, is another metabolic problem, due to the spillage of bile salts into the colon. This complication can cause a number of problems. Dehydration can help to promote the formation of stones in the kidney. A number of minerals can be malabsorbed due to the diarrhea, particularly potassium and magnesium.

Because of the steatorrhea, there is less calcium available because the calcium is bound to the fat in the intestines forming calcium soaps. With less available calcium, there is more free oxalate, as Dr. Krumlovski indicated. Therefore, increased oxalate absorption ensues. We have been treating this problem with oral calcium carbonate, which most patients have tolerated very well. Calcium binds the dietary oxalate, therefore there is less oxalate absorption. A diet low in oxalate is another way to approach this, but doesn't seem as simple as giving calcium carbonate.

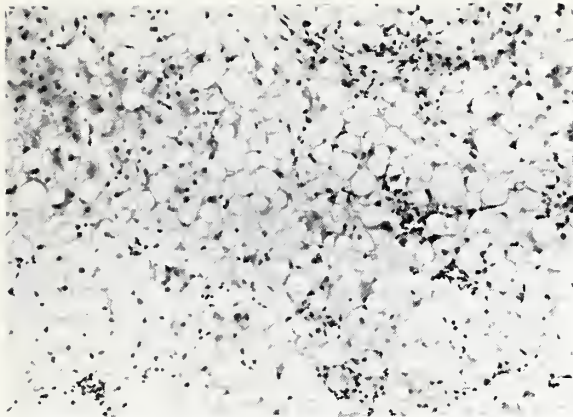
Another complication of patients with intestinal by-pass is the development of cholesterol gallstones, which the last patient demonstrated. Cholesterol is held in solution by micelle formation with lecithin and bile salts. In ileal by-pass, there is a decrease in total amount of bile salts that are available. The usual secretion rate is about 30 grams a day and this is probably decreased to a range of about 8 grams a day in patients with ileal by-pass. Therefore, there is a propensity for bile saturated in cholesterol and cholesterol gallstones develop because there are insufficient bile salts to maintain micelle formation.

**Hepatic Problems**

The final complication, also perhaps a result of altered bile salt metabolism, concerns hepatic problems. Doctor Wirman will discuss some of the liver changes.

**Dr. John Wirman:** The liver pathology associated with intestinal by-pass is morphologically indistinguishable from the liver pathology of alcoholic liver disease. Most of the patients in the initial high weight loss period which, some studies have shown, correlates well with protein malabsorption, develop infiltration of the liver. In most patients this resolves; in some cases, the patients develop disease which is clinically very similar to alcoholic hepatitis, with jaundice, elevated liver enzymes, and fever and leukocytosis. The liver picture in these patients is mor-





**Figure 1.** Micrograph showing acute hepatitis 12 months post by-pass. Note the marked fatty change and the numerous foci of hepatocyte necrosis with polymorphonuclear leucocytic infiltration.

phologically indistinguishable from alcoholic hepatitis. Some of these patients die in acute liver failure, some develop cirrhosis, and others resolve.

I will illustrate the spectrum of changes we see. In one patient, a liver biopsy was done at the time of cholecystectomy, two years after by-pass surgery, which essentially showed no pathologic changes. The hepatic architecture was in very good array and there were no areas of inflammatory exudate. Thus, two years after her by-pass, this patient had essentially no pathologic changes attributable to her by-pass.

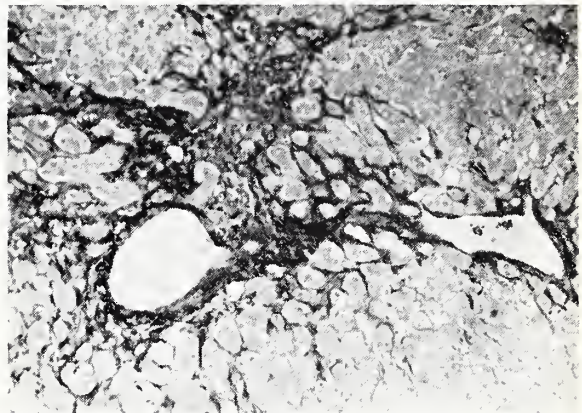
Another patient was admitted for acute hepatitis 12 months after by-pass surgery. The most striking change is this diffuse marked fatty infiltration. The portal fields contain a marked chronic inflammatory infiltrate and there is some evidence of hepatic eosinophilic degeneration. In addition, within the lobule, there are several foci of inflammation, mainly of lymphocytes.

Trichrome stains show that there is only a very slight amount of fibrosis, but interestingly enough, it is diffuse fibrosis, which is the type characteristic of alcoholic liver disease. There is some increase of fibrosis in the area of the portal fields. So, this latter liver biopsy demonstrates the changes that are frequently seen. There is a marked fatty infiltrate, diffuse and periportal fibrosis, a slight portal and lobular inflammatory response, and some evidence of liver cell degeneration. (Fig. 1)

#### Another Case History

The last case we will discuss is a lady who had a liver biopsy done 18 months after intestinal by-pass surgery, incidental to repair of a

ventral hernia. There was no significant history of liver disease in the intervening period; however, this is a wedge biopsy and one has to be careful in interpretation of biopsies of tissue from just under the capsule. Sensitivity must be lowered because there is a lot of normal fibrosis in this area. This diffuse fibrosis in this area is definitely abnormal. There is more fibrosis about the portal fields than one would expect (Fig. 2) and increased fibrosis in the portal fields. The lobule, however, is intact and there is no inflammatory infiltrate.



**Figure 2.** Trichrome stain of a biopsy done 18 months post by-pass on a different patient, who had no symptoms of liver disease. No hepatitis is present, but marked pericellular fibrosis is present.

**Table 2**  
**Intestinal By-Pass**

Code	Age	Greatest Weight	Preop Weight	Date of Surgery	Current Weight	Result
BB	30	365	365	7/21/72	192	Good
JD	36	476	476	7/21/73	200	Good
AH	25	320	283	2/26/74	158	Fair
SK	29	303	294	6/24/74	194	Good
ML	52	400	400	7/28/75	304	Good

#### Summary

In summary, liver disease associated with intestinal by-pass is morphologically indistinguishable from alcoholic liver disease, consisting of marked fatty infiltration, inflammatory exudate with polymorphonuclear leukocytes and both portal and the characteristic diffuse pericellular type of fibrosis. Mallory bodies are frequently seen. It is very interesting that this lesion occurs in this condition because there has been a long argument as to whether alcoholic liver disease was a direct toxic effect of alcohol or to malnutrition. For a while argument was resolved on the side of the former. ◀



# 1000 Crowd Malpractice Rally



Over 1000 physicians, spouses and hospital administrators jammed the 1976 Legislative Conference and Malpractice Rally in Springfield on May 12, to meet with their legislators and discuss the issues of special medical significance currently before the legislature. During the morning, rally participants were briefed on three issues: 1) the legislative package developed by the ISMS sponsored Task Force on Professional Liability, 2) informed medical consent, and 3) antisubstitution repeal. Most participants then had lunch with their legislators, followed by individual meetings with other Senators and Representatives during the afternoon.



The morning briefing session was lead by Dr. Elliott Partridge, Chairman of the Public Affairs Committee (center). Others seated are Dr. Toni Szed, President, Osteopathic Association, Dr. Fredric Lake, Chairman of the ISMS Task Force, Dr. Robert Fox, Chairman, ISMS Board, and Robert Schinderle, President, Illinois Hospital Association.



Participants attentively listen to briefing.

At 3 p.m. a massive rally was held on the East steps of the Capitol Building. The participants were addressed by several Senators and Representatives, as well as key leaders of ISMS. Walter Whistler, M.D., Chairman of the Legislative Initiatives Committee of the Task Force on Professional Liability discussed current negotiations with the Illinois Trial Lawyers Association. J. M. Ingalls, M.D., Immediate Past President of ISMS, urged participants to continue their involvement and increase their legislative contacts. Joseph Skom, M.D., ISMS President, capsulized the entire day of activities with a call for perseverance in the face of adversity. (NOTE: These remarks came 2 days prior to the Supreme Court decision.)

The day concluded with the annual ISMS Legislative Reception attended by conference participants and most members of the legislature. ◀



Dr. and Mrs. Albert Ray (left) discuss the day's activities with Dr. George Wilkins, ISMS President-Elect, and Dr. and Mrs. James Laidlaw.



# Scenes from the Legislative Reception . . .



Dr. Howard Burkhead (left) listens to Dr. A. E. Steer present his point of view to Senator John Nimrod (center).



Dr. Joseph Skom, ISMS President, enjoys a light moment with Senator Cecil Partee and Dr. Herman Wing.



Dr. Allan Taylor and his wife, Pam, Chairman of IMPAC, pose with Senator Tom Merritt and a physician friend.



A group of Will-Grundy County physicians give their opinions to Senator James Bell (second from left).



Dr. Gerald Riordan (left) enjoys the conviviality of the reception with Katherine Trapp and Senator Frank Ozinga.



Mrs. Willard Scrivner (left) with Representative Celeste Stiehl.



Senator Robert McCarthy (left) discusses the issues with a physician-lobbyist.



Representative John Merlo (left) and Dr. Joseph Skom, ISMS President, talk together.



Senator Kenneth Hall (right) jests with some physicians at the legislative reception.



Dr. James Bunting (left) talks about lighter matters with Representative Michael McClain.





Representative Charles Campbell (left) is surprised by the point Dr. and Mrs. Allan Taylor are making.



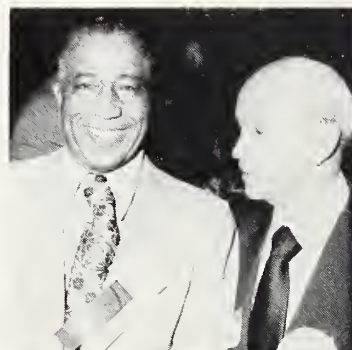
Senator James Philip (left) pauses for a picture with several physicians, including Dr. Robert Garsich (right).



Representative Anne Willer reflects on the days events with Representative Leroy Van Duyne.



Senator Don Moore (left) with Dr. John Seward.



Senator Kenneth Hall (left) laughs at Dr. Willard Scrivner's wit.



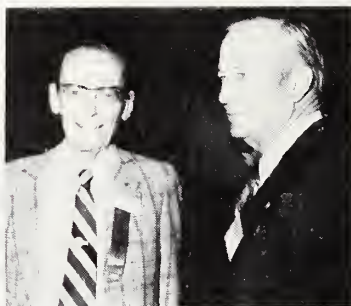
Senator Jack Schaffer shares the conviviality of the reception with Drs. John Seward and Keith Wrage.



Representatives Pete Peters, Donald Arnell and William Mahar (left to right) seated together at the reception.



A physician participant discusses the issues with Senator Ben Palmer (center) and Dr. Willard Scrivner (right).



Senators Tom Merritt (left) and Clifford Latherow joined in the end of day activities.



Senator Cecil Partee (left) listens as Roger N. White, ISMS Executive Administrator, makes a point.

***Congratulations to all participants for a successful  
Springfield Legislative Conference!***



# Doctor's News

**OFFICIAL TRIPLICATE PRESCRIPTION BLANKS OBTAINED FROM R & E**—As of July 1, official state prescription blanks for ordering designated products must be obtained from the Department of Registration and Education. Previously they were obtained from the Department of Law Enforcement. New supplies must now be ordered from the Triplicate Prescription Section, Department of Registration and Education, 628 E. Adams St., Springfield, Illinois 62786. The cost has been set at \$5.00 for each 100 padded prescription forms.

**NEW THIRD DISTRICT TRUSTEE**—Seated at the Board of Trustees meeting on June 12, as the new trustee from the third district was Alfred J. Faber, M.D., He was selected to fulfill the unexpired term of Dr. George Shropshear who had resigned.

**PHYSICIANS CAN APPLY FOR THE AMA PHYSICIAN'S RECOGNITION AWARD** at any time, rather than on a three-year cycle. In the past six years, 64,149 physicians have qualified for the continuing medical education award. Beginning this year, AMA members will pay no application fee toward the award. Non-members will be charged \$25.

**INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS**—A non-dues-paying organization of physicians and dentists who get together at least yearly to help each other obtain and maintain their sobriety and freedom from drugs. The next annual convention will be held at the new Los Angeles Marriott Hotel, August 5 through 8, 1976. Inquiries and newcomers welcome. For information write: Secretary, IDAA, 1950 Volney, Youngstown, Ohio 44511.

**INTERSTATE SCIENTIFIC ASSEMBLY**—The 61st Annual International Scientific Assembly of Interstate Postgraduate Medical Association will be held at the Atlanta Marriott Hotel, November 15-18, 1976. This program is designed for Primary Care Physicians practicing in the U.S. and Canada. It has been planned cooperatively with the Georgia Academy of Family Practice, the Emory University School of Medicine and the Medical College of Georgia. The program consists of lectures, informal group discussions, "live" closed-circuit TV and medical movies on a variety of topics with major emphasis in family practice, internal medicine, obstetrics and gynecology and psychiatry. For further information write: Alton Ochsner, M.D., Program Chairman, IPMA, P.O. Box 1109, Madison, Wisconsin 53701.

**PHYSICIANS IN THE NEWS**—Lawrenceville began its celebration of the United States' 200th birthday with a parade led by Grand Marshals Tom Kirkwood, M.D. and Malcolm C. Todd, M.D. These men were chosen to be honorary parade marshals because of their services to the community.

Dr. Kirkwood has served the medical needs of Lawrenceville for over 50 years. He retired from active practice in 1967 but is still very active in community and civic affairs and makes daily visits to the hospitals to visit former patients. He is also Chairman of the Utilization Review Committee of the Lawrence County Medical Society. Dr. Todd grew up in Lawrenceville. His interest in the medical field was influenced by Dr. Kirkwood. Dr. Todd is a Past President of the American Medical Society and now lives in Los Angeles, California.



Dr. Todd and Dr. Kirkwood at the beginning of the parade.

New officers of the Illinois Academy of Family Physicians were elected at its 28th Annual Meeting held recently at the Hyatt Regency Chicago. **Lawrence Hirsch, M.D.**, Chicago, was inducted as President. Other new officers are **Loren Boon, M.D.**, Danvers, President-Elect; **Delburt Nelson, M.D.**, Chicago, Vice President; and **Eugene S. Welter, M.D.**, Aurora, re-elected Speaker of the Congress of Delegates.

**Charles R. Daisy, M.D.**, Greenville; **William T. Hodges, M.D.**, Kankakee; and **John J. Hurley, M.D.**, Chicago, were elected to three-year terms as members of the Board of Directors of IAFP. Delegates to the American Academy of Family Physicians from Illinois will be **Boyd E. McCracken, M.D.**, Greenville and **A. Everett Joslyn, M.D.**, Melrose Park. **E. Chester Bone, M.D.**, Jacksonville will serve a third two-year term as an Alternate Delegate to the AAFP from Illinois.

**Jack L. Gibbs, M.D.**, Peoria, was named Alumnus of the Year at the University of Illinois, College of Medicine, for service to medical organizations. Dr. Gibbs is assistant clinical professor of surgery at the Peoria School of Medicine and a member of the College of Medicine Committee on Admissions. He is also a member of the Illinois Surgical Society's Board of Governors, a delegate and secretary of the ISMS delegation to the AMA, and past chairman of the ISMS Council on Education and Health Manpower.

Governor Walker has appointed five ISMS members to the new Medical Disciplinary Board: **W. C. Scrivner, M.D.**, Belleville; **Helen C. Bonbrest, M.D.**, Chicago; **Raimundo Rodriguez, M.D.**, Murphysboro; **Levon Krikor Topouzian, M.D.**, Chicago; and **James B. Williams, M.D.**, Chicago.

The Illinois Psychiatric Society recently installed new officers at its May, 1976, Council meeting. **Alex J. Spadoni, M.D.**, Hinsdale, will serve as president of the 900-member organization. **Roy R. Grinker, Sr., M.D.**, Chicago, is the new president-elect; and **Robert deVito, M.D.**, Downers Grove, Treasurer. Councilors are **Thomas Turlentes, M.D.**, Rock Island; **Bernard Rubin, M.D.**, Chicago; **Brenda Solomon, M.D.**, Glencoe; and **Evan G. Moore, M.D.**, Chicago. Other officers of IPS include **Clifton Rhead, M.D.**, Oak Brook, Secretary; **Patrick R. Staunton, M.D.**, Oak Park, delegate, **Francois E. Alouf, M.D.**, Chicago, alternate delegate; and **Nathaniel Apter, M.D.**, Chicago, **Ray R. Grinker, M.D.**, Chicago, and **David L. Rosenberg, M.D.**, Highland Park, as councilors.

**George E. Shambaugh, Jr., M.D.**, was recently honored by his colleagues and former students during the Shambaugh Fifth International Workshop on Middle Ear Microsurgery and Fluctuant Hearing Loss. A scroll presented to Dr. Shambaugh noted his introduction of microscopic ear surgery to the U.S. and expressed appreciation for contributions to that field. His colleagues presented a portrait of Dr. Shambaugh to Northwestern University Medical School that "it may honor him through the ages."

New staff officers have been elected at several hospitals. At Englewood Hospital, Chicago, for 1976-77, **Alexander Bernstein, M.D.**, a radiologist will serve as president of the medical staff, **Ernesto Chua, M.D.**, vice-president; **Renato Tanquilut, M.D.**, secretary, and **Lucy Evangelista, M.D.**, treasurer. Medical staff officers for 1976 at Northwest Community Hospital are **Richard Howell, M.D.**, an obstetrician-gynecologist, president; **John Lynch, M.D.**, vice-president, and **Alfred Clementi, M.D.**, secretary-treasurer. Jackson Park medical staff officers were all asked to serve another year. They are **Maynard I. Shapiro, M.D.**, president; **S. Y. Yap, M.D.**, vice-president; **L. I. Silverman, M.D.**, secretary, and **D. L. Foster, M.D.**, treasurer.



# Doctor Finds New Cure for Malpractice Suits

BY WAYNE B. GIAMPIETRO, ESQ./CHICAGO

*"Every person shall find a certain remedy in the laws for all injuries and wrongs which he receives to his person, privacy, property or reputation. He shall obtain justice by law, freely, completely, and promptly." Constitution of the State of Illinois, Article I §12*

Dr. Leonard Berlin had been wronged. He seethed inwardly. He was not about to take it lying down. So he did something about it, and became the first doctor in memory to successfully carry a suit against a patient and attorneys to a favorable jury verdict for filing an unfounded medical malpractice suit against him. While similar success cannot be guaranteed for every doctor who prevails in a medical negligence suit brought against him, his victory signals that the more outrageous of those suits will be curtailed drastically. Doctors are no longer helpless in the face of the seemingly uncontrolled rise of such suits. This landmark verdict shows that courts and juries are willing to listen carefully to the complaints of medical men that they are being wronged in many instances, and ready to compensate them for damage which is needlessly inflicted upon them.

## Scenario

This story starts routinely enough. Dr. Berlin, radiologist at a suburban Chicago hospital, was surprised when Harriet, one of his neighbors, with whom he had a slight acquaintance, appeared in the waiting room of his hospital on October 1, 1973. Upon learning that she had injured her right little finger playing tennis, Dr. Berlin directed the laboratory technicians to take the necessary X-rays with as much dispatch as possible. He immediately read the X-rays, and diagnosed a dislocation of the finger. Harriet was then directed to the emergency room where noted orthopedist, Dr. William Meltzer, concurring in the diagnosis, reduced the dislocation and applied a splint, directing her to return for follow-up examination within a week.

Harriet did not return to Dr. Meltzer within that period of time, but approximately three weeks later appeared at the office of Dr. Meltzer's partner. Additional X-rays were taken at that time, which disclosed a small chip-fracture at the base of the middle phalanx of her right little finger.

Dr. Berlin never saw Harriet again in connection with this matter, and had nothing more to do with the treatment of her injury. Thus, he was stunned to receive a call a year-and-a-half later from Harriet's husband, Gilbert, an attorney, stating that he was making a "courtesy" call to inform him that they were considering suing Dr. Meltzer for malpractice and would have to include Dr. Berlin as a defendant since he had read the original X-rays. Gilbert's main complaint was that the orthopedist had not taken his wife's injury seriously, was abrupt and too fast. What really made him angry was that a cousin of his had attempted to call the orthopedist for information about the treatment and had been "given a run around" and couldn't get to first base. Dr. Berlin vainly attempted to explain that even if the fracture could have been seen and diagnosed initially, the treatment would have been exactly the same and that any continuing disability on Harriet's part was due to the injury caused by the tennis accident, not the treatment given. Dr. Berlin continued that regardless of any complaint about the orthopedist this was no reason to involve him, and that as a fellow professional he ought to be aware of the ridiculousness of the charge he was making. Gilbert remained adamant, however, stating that if his wife's finger did not improve, he would have to take legal action.

Dr. Berlin, of course, began to make inquiries, and discovered that Harriet had subsequently seen another orthopedist for consultation, who had written a report of his findings, a copy of which he had sent to Dr. Meltzer, who in turn provided a copy to Dr. Berlin.

It did not come as a complete shock to Dr. Berlin, then, when he was served with a summons and complaint eight months later. What did shock him, however, were the charges which were made against him in the malpractice complaint. In addition to being charged with having failed to diagnose the fracture, he was accused also of: failing to X-ray all necessary views of the injured finger; wrongfully diagnosing a dislocation causing Harriet to sustain improper treatment; failing to let the X-rays dry long enough to obtain a clear picture before reading them; and that he had been "otherwise careless and negligent."

Reading this complaint was the last straw. While the charge that he had failed to discover the fracture was not entirely unexpected, the other accusations were totally without foundation. What is more, there was no possible basis for them. Neither Harriet, Gilbert, nor her attorneys could have had any information which would support them.

### Alternatives

Dr. Berlin decided to counter-attack. He, along with most medical men, had been alarmed by the rising tide of malpractice claims, some totally without foundation, and many of which, while containing at least arguably valid claims, named all medical personnel who had come into contact with the patient at any time. While his liability insurance carrier had provided him with excellent defense counsel, who assured him that the claim would undoubtedly not stand up and would almost surely never come to trial, Dr. Berlin was not satisfied. He was not content to let the matter drag on for years, with the possibility that the insurance carrier would decide to pay a nuisance amount to get rid of the case because doing so would cost less than trying the case to a verdict.

Along with some attorney friends, he sat down to devise a method to bring the subject of frivolous and unfounded claims into the open. While causes of action for malicious prosecution and abuse of process are well-recognized in Illinois and other states, such a suit cannot be commenced until the prior litigation has been concluded in favor of the wronged defendant. To wait two or three years until the conclusion of the malpractice suit was not what they had in

mind. They wanted to bring the grievance to a head immediately. So they devised a novel theory, charging Harriet, her husband, Gilbert, and the attorneys with willful and wanton misconduct—a reckless disregard of Dr. Berlin's rights. This suit was filed as a separate and independent action, but was subsequently consolidated with the malpractice suit, to be tried before the same judge. Indeed, the cases were set to be tried together, the malpractice suit as the main claim, Dr. Berlin's suit as a counterclaim—to be heard and determined by the same jury. However, that was not to come to pass.

### Response

The initial reaction to Dr. Berlin's suit was somewhat in the nature of tolerant amusement. Predictions were that it would be dismissed immediately. The tables were soon to turn, however. The doctor's suit was not dismissed. It was subsequently amended to add another count, against the attorneys only, charging them with having filed Harriet's suit without a reasonable basis or cause, thereby falling below the standards required of attorneys to perform their professional duties in good faith, or in other words, being negligent. The complaint withstood attacks that it did not state a legal claim, and both cases were set for trial. Suddenly, on the very morning that the trial was to start, Harriet's attorney announced to the Court that she was dismissing her suit on her own initiative, with prejudice, meaning that it could never be filed again. While urged by many that he had been fully vindicated, and ought to likewise dismiss his suit, Dr. Berlin refused, and insisted on having his jury trial.

### At Issue

Trial lasted three days. Predictions were that while he had a good chance of prevailing against Harriet, and perhaps Gilbert as well, he would most probably not be successful against her attorneys. Instead, the jury returned a verdict awarding Dr. Berlin \$2,000.00 actual damages and \$6,000.00 punitive damages jointly against all defendants.

The trial itself was ordinary in many respects. Dr. Berlin and Dr. Meltzer testified to the treatment which they had given Harriet and its propriety. No one was produced by the defendants to counter this testimony.

The evidence of the defendants' actions, however, was devastating. Harriet first contacted an attorney, other than her husband, little more than a month before the statute of limitations



was due to expire, at which time only preliminary discussions were held. On September 8, 1975, she delivered to her attorneys a written statement, prepared by her, the letter from the last orthopedist whom she had seen, dated nearly a year previously, the emergency room report of the treating orthopedist, and copies of Dr. Berlin's written report of his findings upon viewing the X-rays taken of her finger nearly two years previously. Echoing the statements of Gilbert to Dr. Berlin, she stated that the treating physician's attitude was extremely casual and offhand, and that he had dismissed the incident as trivial and unimportant. While she reported that she had been told to return within 10 days of the original injury, she failed to state that she had not returned to see any physician for three weeks. She made several allegations as to what subsequent doctors she had seen stated to her which were flatly denied by those doctors at the trial:

1. She had not suffered a dislocation of her finger;
2. Certain required angles were not taken in the X-rays;
3. The original splint had been placed incorrectly on her finger;
4. The presence of the bone fragment from the chip fracture at least partially caused her the loss of the use of her finger;
5. All of the X-rays taken, including the original ones before any treatment was given, showed the fracture;
6. Her injury had been treated too lightly;
7. If another of the orthopedists had treated her originally he would probably have performed surgery immediately, but could not do so by the time she came to him;
8. The condition of her finger, being permanently bent, stiff and sore, was totally unnecessary and could have been prevented if proper and prudent care had been administered to her at the time of the accident.

The attorneys who decided to take her case did not know at the time that these doctors would deny all of these statements, because they made *no attempt whatsoever* to contact either of the two doctors she claimed had made these statements attributing malpractice to Drs. Berlin and Meltzer. Instead, they immediately drafted a complaint and filed it three days after receiving her statement. They admitted at the trial that at the time they drafted and filed it, they

had no basis for stating that Dr. Berlin had failed to take the proper views of the finger, wrongfully diagnosed a dislocation, failed to let the X-rays dry long enough, and had been otherwise careless and negligent. These allegations were explained at the trial as being the usual claims made in a medical negligence case, which could be dropped from the suit if subsequent discovery proved them to be unfounded.

### **An Attorney's Duty**

However, as forcefully brought out at the trial by the legal experts who testified on behalf of Dr. Berlin, there were certain indications in the material which Harriet presented to them which should have put any reasonable attorney on notice that many of her allegations were not correct. The letter from the subsequent treating orthopedist when read in its entirety gave no hint that any improper treatment had been given to Harriet by prior doctors. Rather than supporting her claim that her finger was totally stiff and bent and unusable, the letter indicated that she in fact had considerable freedom of movement in it, which improved significantly between the first and second time she visited him, about six weeks apart. Most importantly, however, his letter flatly contradicted her statement that all of the X-rays disclosed the chip fracture, clearly stating that only those taken three weeks subsequent to the injury showed it. It was the testimony of these experts that these obvious discrepancies between her story and the report of this physician should have caused any prudent attorney, exercising the usual skill and prudence in the community, to conduct at least an initial investigation into her allegations. They pointed out that even though time for filing the suit was short, some attempt should have been made to contact the doctor who had written the report which she tendered. In their opinion, the failure to take this clearly indicated step was negligence on the part of the attorneys.

Their opinion was based upon the duty which an attorney owes: 1) not to involve a client in frivolous and unfruitful litigation; 2) not to burden the courts with unfounded claims; 3) not to make an allegation against an opposing party without some reasonable cause to believe that there is some basis for it, particularly if it might harm his professional standing and reputation; and finally 4) not to harm his own reputation by advancing frivolous and unfounded litigation. Several disciplinary rules and ethical considerations as set forth by the American Bar Association were relied upon in reaching these conclu-

sions, among which are:

A lawyer should not handle a matter without adequate preparation;

A lawyer is not justified in asserting a frivolous position;

A lawyer must treat with consideration all persons involved in the legal process and to avoid the infliction of needless harm;

A lawyer should not file a suit when he knows or it is obvious that such action would serve merely to harass or maliciously injure another.

Obviously, the fact that members of the legal profession were willing to take the witness stand and testify under oath that fellow-attorneys had not acted with the proper care and expertise was critical to the conclusion reached by the jury. Had it not been for the willingness of such men to step forward, the likelihood that the attorneys would have been held liable in this case would have been lessened considerably. Without such testimony there is little doubt that they would not have been found liable along with Harriet and Gilbert.

As for Harriet and Gilbert themselves, their testimony during the trial was truly their own undoing. It became obvious that the charge that subsequent doctors had been critical of the treatment initially given her was their opinion alone. They were the ones who stated to the third doctor whom they consulted, that the second doctor had been critical of the first. They then, in turn, told the second doctor, that the third had been critical of the first. Both doctors denied that they had ever made any such statement or had even implied any such criticism.

The eagerness of Gilbert to insulate himself from any liability for the actions of his wife and her attorneys obviously led the jury to discredit most of his testimony, as well as much of his wife's. He claimed that he had never spoken to Harriet's attorneys about the filing of a suit on behalf of his wife. Yet, it was he who had obtained what records were given to them, personally delivered them to their offices, placing on top a note requesting that he be allowed to review the complaint in his wife's case before it was filed. It was also he who had written, on his law office letterhead, to the doctor, requesting the written report on the condition of his wife's finger.

His testimony, echoed by his wife, that the

two of them had never discussed between themselves the filing of a malpractice suit by her, was simply not believed by the jury. Nor was Harriet believed when she testified that she was unaware that a written report had been prepared by the consultant or requested by her husband. It is surely this absolutely unbelievable testimony which went a long way toward convincing the jury to award Dr. Berlin \$6,000.00 in punitive damages.

When the jury signalled that it had a verdict less than an hour after the case had been submitted to it for deliberation, there was some concern in Dr. Berlin's camp. Normally, when a jury returns a verdict quickly, it is a sign that its decision is in favor of the defendant, on the theory that a short period of deliberation signifies that the jurors have not had time to deliberate upon the amount of damages. Everyone in the courtroom was amazed when the jury verdict was opened and read, awarding \$2,000.00 actual damages and \$6,000.00 punitive damages. Not the least amazed was Dr. Berlin's attorney, who had only requested the jury to return a total verdict in favor of his client for \$3,000.00 (\$1,000.00 actual and \$2,000.00 punitive).

### Reactions

Dr. Berlin had set out to prove a point. He was not seeking any substantial amount of damages, for his actual losses had been little, consisting mostly of time spent preparing to defend the suit brought against him. He was not motivated by any vindictiveness against the defendants he had named. That he proved his point even better than he had expected was doubly gratifying.

Even more surprising was the public reaction to the result. While he and his attorney were aware that there was considerable interest in the case, neither of them were prepared for the actual reaction from the medical profession, the news media, and even from the legal profession. Almost without exception, the reaction to this case has been favorable on all of these fronts. Everyone realizes that while there are indeed legitimate complaints of medical negligence, great abuses have arisen in the area. It is not the legitimate cases of malpractice (even those where large verdicts or settlements have been awarded) which have caused a fantastic upward spiral in medical liability insurance, but the plethora of small "nickel and dime" cases, which cost nearly as much to investigate and defend. The result in Dr. Berlin's case is a heartening indication that the legal system does and can



work to the advantage of everyone, including the medical profession, if they will but utilize it properly.

This, of course, is not to say that every doctor who is named as a defendant in a malpractice case is entitled to recover as Dr. Berlin has, or should file a similar countersuit. As was so graphically demonstrated in this case, before a suit of any kind is filed, you must be sure of your facts. If an attorney or doctor is seriously considering filing such a claim, he must investigate his proposed cause of action to as great a degree as he

would expect his opponent to have investigated his. The rules are the same for all—frivolous or unfounded allegations may well subject the ones propounding them to money damages.

The moral to be gained from this case is much broader than the specific fact situation involved here. The courts are open to everyone. Anyone is free to file a suit against anyone else, by the payment of a small fee. But, as always, freedom carries with it the duty to act responsibly. If that freedom is abused, a penalty will be exacted. ◀

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*Editors Note:* IMJ is indebted to Dr. Berlin and Mr. Giampietro for this article. It should be noted that Mr. Giampietro received valuable assistance during the trial from Mr. Fred Grossman, Esq., the attorney for The Hartford defending against the original malpractice claim. Dr. Berlin has received many favorable responses and comments.

ISMS became interested in Dr. Berlin's claim last December. Monitoring and clearing house functions were established through the Task Force on Professional Liability Committee on Moves to Counter Litigation.

Research of various items, shepherdizing similar cases, and statistical data accumulations were accomplished for sharing with Dr. Berlin.

Recent activity, subsequent to this jury award, indicates the matter may be taken on appeal. The ISMS Board of Trustees has authorized an *amicus curiae* brief in any appeal of this, as well as provision of assistance to Dr. Berlin.

The precedent of this case presently maintains only in Cook County. However, the ramifications could be far-reaching. A decision by a higher court will provide state-wide application.

Following is an article based upon 1975 opinion research. Related to this is a brief "Your Opinion" survey taken through the pages of the May IMJ. Initial results indicate the following:

1. Have you altered your practice or mode of practice as a result of possible claims of negligence?  
Yes 86% No 14%
2. Are you practicing more "defensive medicine?"  
Yes 92% No 8%
3. Are you limiting the procedures or services you provide in order to reduce exposure to possible suits?  
Yes 80% No 20%

Upon receipt of further replies a more complete review of the results is to be prepared.

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# The Malpractice Crisis: Views of Illinois Physicians\*

BY ESTER GOTTLIEB SMITH AND PAULA ROGGE/URBANA

*The dramatic increase in malpractice premiums and the withdrawal of a number of insurance companies from professional liability insurance triggered a series of strikes and demonstrations by physicians in major cities all over the United States. Physicians protested the skyrocketing costs of malpractice insurance and demanded from state legislators an immediate solution to the malpractice crisis.*

*Although the term "medical malpractice" has suddenly become familiar to the public, the crisis, Dr. Welch notes,<sup>1</sup> had been foreseen by the medical and legal professions for many years. A more litigation conscious public, aggressive trial lawyers, and the weakening of personal relations between physicians and patients were mentioned among the main causes of the malpractice crisis. The most immediate cause, however, most reports agree, is the almost geometric progression in the number of malpractice claims and the equally steep escalation in malpractice awards.*

\*This survey was conducted during July and August, 1975, when Ester Gottlieb Smith was a Visiting Research Assistant Professor and a Project Coordinator in the Survey Research Laboratory at the University of Illinois, Urbana, Illinois.

## Background

In the last ten years, malpractice claims against physicians and hospitals have been increasing at

a rate greater than 12% annually.<sup>2</sup> In the last two years, in fact claims are estimated to have increased by approximately 22% annually. The St. Paul Fire and Marine Insurance Company which writes coverage in 44 states estimated that the malpractice claims against physicians it insures were running at a rate of 5000 a year in 1975, which is a 225% increase over 1538 claims logged against this company in 1970. Furthermore, St. Paul does not write policies in California and New York which lead the nation in the number of malpractice claims.<sup>3</sup>

Especially vulnerable to malpractice suits are physicians in high-risk specialty areas. A Maryland study found that one of every three orthopedic surgeons and one of every four obstetrician-gynecologists and anesthesiologists are involved in malpractice litigation.<sup>4</sup> A government study drew the same conclusions: "Particularly vulnerable were orthopedic surgeons, urologists, obstetrician-gynecologists and general surgeons in descending order."<sup>5</sup>

Insurance companies have started taking drastic action: many have increased malpractice premiums by 200-300% in the last year, others dropped policies with physicians in high-risk specialties, and some pulled out of the malpractice insurance market altogether.<sup>6</sup>

Physicians' reactions to this situation were immediate and dramatic. Anesthesiologists in California called a walk-out first in San Francisco and then in Los Angeles when their premiums zoomed from \$5,377 to \$18,164. Similar walkouts and withholding of non-emergency services were staged in New York, Rhode Island, and Texas after those state governments either failed or declined to deal with the problem of soaring malpractice premiums.

In many states legislation was drafted that would create a joint underwriting association by which the sources of many insurance carriers could be pooled. Most doctors consider such laws "stop-gap" measures, contending that under these laws premiums would remain high because there would be no substantial change in the way malpractice suits would be adjudicated. Instead, they advocate plans resembling the one adopted in Indiana which limits malpractice damage awards, allows payment of all awards over a certain limit by a state fund, establishes a medical review or screening panel, and tightens the statute of limitations.

### Sample and Demographic Information

Questionnaires were mailed to 277 physicians

sampled on a probability proportional to size basis from four lists of a total of 550 physicians listed in the telephone directories of four cities in Illinois with populations ranging from 43,000 to 100,000. The data were collected in July and August 1975, using two mailings and a telephone follow-up. One hundred and seventy-six physicians completed the questionnaire, approximately 64% of the total sample or 67% of those who could be contacted.<sup>7</sup>

About 30% of the returns were from physicians in high-risk specialties: general surgery, orthopedic surgery, obstetrics-gynecology, and anesthesiology. The mean age of the respondents was 49, and the overwhelming majority were male (97%) and white (92%). The mean income of the respondents was approximately \$59,000 and 87% consider themselves politically conservative or moderate. Two-thirds of those surveyed had a fee-for-service practice and of those, approximately half were in solo practice or partnership with one other physician.

### Determining Professional Negligence

The first opinion queried was whether respondents felt that the number of malpractice suits a physician incurred was an indication of professional competence. Leading physicians and medical men like Professor William Curran of Harvard University maintain that "Most malpractice cases aren't a result of faulty doctoring but of the inherent risks of modern medicine with its rapidly developing techniques. It's apt to be the most competent surgeon who gets sued, because he's doing risky surgery."<sup>8</sup> To determine whether Midwestern physicians from small cities felt the same, the following item was included:

*Is the number of malpractice suits a physician incurs against himself or herself an indication of professional competence?*

(N=176)

Definitely not	55%
Not sure	9
Perhaps	31
Definitely yes	3
No answer	2

As it turns out, over half of the respondents in this survey agree with leading physicians and consider recognition by peers (78%), Specialty Board certification (63%), and number of hours spent in training (52%) better standards by which to judge a physician's competence than the number of malpractice suits incurred.



This fairly strong support for peer review is not surprising. In a study conducted by Columbia University in 1973,<sup>9</sup> nearly three-quarters of the physicians interviewed were receptive to a National Health Insurance plan with peer review. California physicians who, in a similar instance, reacted coldly to a Professional Standards Review Office (PSRO) which they suspected would force review by hospital housestaff or by doctors from outside their specialty, changed their initial reaction when they were assured they would be reviewed by peers.<sup>10</sup>

Attitudes toward peer review varied with the type of practice a physician has. The fee-for-service doctor was significantly less enthusiastic about recognition by peers than the service group, hospital or clinic doctor.

*How do you rate "recognition by peers" as a standard of professional competence?*

	Good	Fair	Poor
Fee-for-service n=91	73%	20%	7%
Other (salaried, share of group income, etc.) n=42	91	9	
chi-squared=6.09 2 d.f. p<.05			

The hospital or clinic doctor is part of a group and realizes that his diagnosis and treatment are known to his colleagues. To him peer review, though not termed as such, goes on every day. The fee-for-service doctor is not used to working closely with fellow colleagues and to having his ideas and methods of treatment scrutinized by them. He is more likely to fear that reviewers, because of unfamiliarity with his specialty or type of practice, may judge him unfairly.

### Causes of the Malpractice Crisis

Physicians were asked to consider five possible causes of the malpractice problem and evaluate each one separately.

Most physicians felt that the increase in the number of malpractice claims and awards was due to factors outside the medical profession. Although 40% acknowledged the weakened doctor-patient relationship as a causal factor, most blamed the crisis on "rising expectations on part of the public" and on the consumerism movement which "encourages people to seek remedies in the court for any injury or adverse result."<sup>11</sup> They also blamed aggressive trial lawyers and the system of legal contingency fees which encourages patients to sue whether or not they have a valid case.

*Is the increasing number of malpractice claims due to:*

	Yes	Maybe	No	No Answer
(N=176)				
A. A more litigation conscious public	87%	10%	1%	2%
B. More aggressive trial lawyers	78	17	1	4
C. Greater publicity concerning malpractice suits	76	19	3	2
D. Less communication between doctor and patient	39	43	11	7
E. A lowering in the quality of health-care	2	7	83	8

These responses differ somewhat from physicians' responses to a 1971 AMA survey<sup>12</sup> in which respondents blamed mainly "poor communication between doctor and patient" (40%) and aggressive lawyers (26%) for the malpractice crisis. The difference in views is most readily explained by the rapid escalation of the malpractice crisis since 1971 and the concomitant increase in enmity between doctors and lawyers over legal doctrines and lawyers' contingency fees.

### Solutions to the Malpractice Problems

Of the various solutions to the malpractice problem the ones most favored by the physicians were long term solutions based on changes in the adjudication of malpractice suits rather than the payment of claims. The establishment of state-run, non-binding arbitration panels to screen malpractice claims, limitations on lawyers' fees, and restrictions on the statute of limitations and other legal doctrines were evaluated by three-quarters of the respondents as "very important," 26% rated the establishment of insurance pools which private companies could draw upon when their reserves ran low as important, and only 20% considered payment of all awards over certain limits by a state or federal fund was vital.

Similar solutions were offered by the public in two surveys conducted by the Gallup Poll (May 30-June 2, 1975) and the Harris Survey (June 4-10, 1975).<sup>13</sup> In the Harris Survey 70% or more objected to lawyers' contingency fees (80% in the Gallup Poll), favored "impartial panels of experts to screen all malpractice claims before a case is tried," and supported having malpractice insurance handled by a non-profit fund which would reduce the amount doctors have to pay

for their insurance. Between 49 and 62% in both surveys also approved of restrictions on the statute of limitations and setting an upper limit on the amount a patient could be awarded. In spite of the general sympathy the public holds toward the doctors, the most favorable measure was one requiring the medical profession to do a better job of policing itself, especially to take more effective measures to rid itself of incompetent doctors (85% Gallup Poll).

Age and political views affected doctors' support of the various solutions to the malpractice crisis. Doctors over 40 were more likely to feel that limits on lawyers' fees were very important in solving the malpractice problem (81%) than doctors under 40 (65%).<sup>14</sup> Older doctors were more distrustful of lawyers than younger doctors. The older doctor is perhaps less aware of changes in consumer attitudes and more likely therefore to put the blame on other factors than the younger doctor. It is unlikely that older doctors had more contact with malpractice suits than the young ones, since it is estimated that 90% of all malpractice suits were filed in the last 10 years.<sup>15</sup>

Significantly more doctors who classified themselves as conservatives and moderates, than doctors who identified themselves as politically liberal, strongly supported the establishment of an insurance pool which private companies could draw upon when their reserves ran low.

*How important is the establishment of an insurance pool which private companies could draw upon when their reserves run low?*

	Very Important	Somewhat Important	Not Important
Conservatives n=59	39%	39%	22%
Moderates n=86	19	53	28
Liberals n=19	21	32	47
Chi-squared=12.49 4 d.f. p<.02			

This is expected since an insurance pool to support private companies is a tool to protect the private sector where most of the conservative physicians are employed. A similar correlation between political views and opinions on such health care issues as National Health Insurance and peer review was demonstrated in the Columbia University study.<sup>16</sup> Although physicians' political views are less crystallized around the malpractice issue than around other health care problems, respondents' political views do have a significant

effect on their attitudes toward government involvement in the malpractice crisis.

Most physicians (75%) agreed that the establishment of medical review panels to screen malpractice claims was a preferred solution to the malpractice crisis. However, when respondents were asked about the nature of these panels, 65% maintained that they should be composed of a majority of physicians with representatives of the legal profession and the public. Illinois physicians are willing to share with the public the process of malpractice claim screening as long as they maintain the major control.

**Limits of Government Involvement**

In an attempt to define what the physicians felt were the limits of government involvement in health care, a question on state insurance funds was included.

*Do you feel state insurance funds are a "foot in the door" for state control of medical practice (i.e. compared to physician-owned insurance companies)?*

(N=176)	
Yes	29%
Maybe	48
No	19
No Answer	4

Most respondents expressed some suspicion of government involvement in health care. Conservatives (41%) were more likely to consider state insurance funds a "foot in the door" (i.e. an overstepping of governmental jurisdiction) than moderates (28%) or liberals (11%).

Hostile feelings toward government involvement in the malpractice controversy became more apparent when respondents were asked to give their opinion on a government run health care system. Nearly 80% rejected a government-run health care system and thought it was "definitely not" a solution to the malpractice problem.

"But doctors who are now storming state legislatures and state capitals to demand solutions to their malpractice problems should be aware that they are entering enemy country. The solutions they are inviting may turn out to be even worse than the problems."<sup>17</sup>

Physicians welcome government intervention as long as it means restrictions on lawyers' fees, changes in the adjudication of claims, and reworking of legal doctrines. When, however, there



are intimations of government involvement in other areas, physicians react quite negatively.

### **Autonomy of the Medical Profession**

Physicians are especially sensitive to any restrictions that may limit their autonomy:

"... What would the federal government require of the medical profession as the quid pro quo for removing the specter of malpractice bankruptcy? Essentially, a nationalized medical system. That would mean the end of the considerable autonomy that physicians and other health professionals still have here. . . ."18

Like their colleagues, Illinois physicians strongly opposed any type of external regulation or "policing" (90%). Most physicians (92%) felt that policing for substandard performance should be done from within rather than from outside the medical profession. The great majority considered the problem of policing not one of desire but one of ability on the part of physicians to discipline themselves.<sup>19</sup>

Similar responses were obtained on two other survey questions relating to the issue of medical profession regulation. According to respondents, medical review panels designed to discipline the medical profession should be made up of physicians only (39%) or a majority of physicians with some representatives of the legal profession and the public (47%). Physicians in low risk specialty areas (65%) were more inclined to favor review panels made up of physicians only than physicians in either medium (33%) or high risk (43%) specialty areas. The latter being more prone to malpractice claims are more aware of consumers' attitudes and thus favored the inclusion of legal and public representatives in the medical review panels.

Regulation of physicians is obviously a touchy issue. Even, in fact, if government malpractice

insurance is tied to stricter physician regulation, few doctors may (25%) or will accept it (15%). In spite of the general rejection of stricter physician regulation in exchange for government malpractice insurance coverage, significantly more physicians in high risk specialty areas (52%) than those in low and medium risk specialty areas (38%) will "definitely not" accept this proposition.

Efforts to tie greater physician regulation to malpractice legislation have been common, particularly among more liberal legislative leaders. Senator Edward Kennedy, California Governor Edmund Brown, and Governor Lucey of Wisconsin have all urged that malpractice legislation be tied to demands for periodic recertification and other demonstrations of continued physician competence.<sup>20</sup> As our sample shows, legislators will have a hard time. Physicians are wary of "deals" with the government and show no sign of softening their attitudes on either socialized medicine or outside policing of their profession.

### **Physicians' Involvement in the Malpractice Controversy**

The physicians responding to this survey have been fairly untouched by the present malpractice controversy and assumed a rather passive role. Virtually none (1%) have participated in a picket line or have been part of an organized plan to strike (2%). A small percentage (6%) were members of state or national societies dealing with the issue and were therefore indirectly involved. 17% were either lobbyists (presumably in Springfield) for malpractice legislation or communicated their feelings to legislators and other members of local bar and medical associations. For the most part, however, political activity was minimal.

Not only was actual participation in any type of political activity low, but the number of doctors even considering such options as retiring, moving to another state or striking was small. Retiring early, as shown in the following table, was the most commonly considered alternative, yet most of those considering early retirement were in the over 40 age bracket (79%).

Striking, on the other hand, was more significantly preferred by younger (22%), fee-for-service (18%), and high risk specialists (24%) than by the over 40 (10%), low and medium risk physicians (10%) who have a group practice (6%). The latter are more conservative, and working for a hospital, clinic or institution that



ESTER GOTTLIEB SMITH, Ph.D., is a research associate at Radcliffe Institute in Programs in Health Care, Cambridge, Massachusetts. She graduated from the University of Illinois with a doctoral degree in Communications Research, specializing in public opinion and research methods.

PAULA ROGGE, is a teaching assistant in the Department of Biology of the University of Illinois, Urbana where she is working on a master's degree.



*In light of the present malpractice premiums for doctors have you considered . . .*

	Yes	No	No Answer
	(N=176)		
A. Striking	13%	79%	8%
B. Moving to a state with lower premiums	6	86	8
C. Retiring early	33	63	4
D. Limiting practice to low risk patients <sup>21</sup>	6	—	94
E. Raising fees	4	—	96
F. Going into teaching or government employment	6	—	94
G. Giving up medicine	2	—	98

provides malpractice insurance they are relatively shielded from rapidly escalating malpractice insurance premiums, thus less likely to revert to such drastic measures as striking.

### Organization, Publicity, and Role of the AMA

Contrary to their opposition to increasing state control of the medical practice, most physicians were ready to see medical societies assume a more active role as a bargaining agent.

*Would you direct your complaints about the high costs of malpractice insurance to . . .*

	(N=176)
Your hospital or city association of doctors	3%
Your county medical society	17
Your state medical society	28
Your national medical society	21
State and national legislators	6
Specialty Boards	5
Combination of medical societies and Specialty Boards	20

The largest group of respondents preferred to channel their complaints through their state medical society. The state medical society is considered the most effective association one can direct complaints to.

"The Illinois State Medical Society (ISMS) has an active legislative program and gives unity to the county organizations. The county medical society directs its members to write letters and to do lobbying in Springfield, but the State Society basically spearheads things."<sup>22</sup>

Most Illinois physicians (76%), as physicians in other parts of the country, approved of publicizing their complaints and positions on the malpractice issue on television, radio, and in the newspapers. In New York the state medical so-

ciety raised approximately two million dollars through a special \$100 assessment on each member physician. The money was spent on a newspaper advertising campaign handled by one of the nation's largest public relations companies. The Indiana and California state medical societies called for "a vigorous but mainly low pitched and largely educational effort" to take the malpractice message to the public. Radio spots were prepared by a public relations agency and medical society members appeared in radio and television interviews and spoke at well-attended meetings.<sup>23</sup> This is in keeping with the AMA's past use of the media to influence public opinion.<sup>24</sup>

The final question was included to determine whether Illinois physicians perceive any conflict of interest between the traditional AMA role as a scientific association dedicated to improving the quality of health care and its newer role as arbitrator for and bargaining agent of the medical profession. As the data indicate, physicians not only favored the AMA assuming such a role but they considered it compatible with the traditional role of improving quality of health care and representing the consumers' interests.

*In your judgement should the AMA . . .*

	Yes	No	No Answer
	(N=176)		
A. Maintain its original purpose of sponsoring research and promoting medical education to improve the quality of health care	86%	6%	8%
B. Dedicate itself to improve the status of physicians, thus becoming an agent of bargaining power for physicians	74	16	10

Most physicians approved of the new role as much as of the older one without realizing that such a position is dangerous for the American Medical Association. The AMA is increasingly pursuing two roles, as Theodore Marmor observes in his book *THE POLITICS OF MEDICARE*, that of representing the public and that of representing the physicians' interests. This mixture of trade unionism and professional activities in the AMA, Marmor warns, has undermined the credibility of either role.<sup>25</sup>



## How Central Illinois Physicians Compare With East and West Coast Physicians

A sampling of news media coverage shows that physicians in New York and California, areas where the malpractice crisis hit hardest, are similar to Central Illinois physicians in their evaluation of the malpractice problem, including their opinions on the causes and solutions to the malpractice crisis, on regulation of physicians, on government involvement in the malpractice controversy, and on the role of the AMA in the issue. The main difference between Central Illinois physicians and the rest of the nation's doctors lies in degree of political activity and involvement with the crisis. Whereas the Midwesterners interviewed are relatively "untouched" by the controversy and only a few participated in strikes, picketing or other forms of organized protest, a considerable percentage of East and West Coast doctors were and still are involved in massive work-stoppings, intensive lobbying, and in the formation of physician-owned insurance companies.

In the midst of such vigorous activity, Illinois appears relatively calm. The small number of physicians who are active prefer lobbying and

medical society meetings dealing with the crisis to more drastic measures. The moderate dimensions of the malpractice problem in Central Illinois, where data were collected, is possibly due to the lower number of claims in Central Illinois than the number upstate and to the insurance premiums for downstate doctors. According to the Illinois State Medical Society, 77% of all reported malpractice claims in Illinois were from the upstate, more densely populated counties such as Cook, Lake, Peoria, and St. Clair.<sup>26</sup> However, in an AMA assessment of the availability of coverage in different states in August, 1975, Illinois was favorably rated, although Medical Protective, one of the two major insurers in state, was "looking at renewals for Cook County."<sup>27</sup> Classified as a state with "a problem developing but not serious," Illinois physicians, mainly those who practice downstate, have thus far not come in contact with the most unpleasant and pressing aspects of the malpractice problem. ◀

### References

A list of references for "The Malpractice Crisis: Views of Illinois Physicians" may be obtained by writing *IMJ*, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.

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## Pioneer Gershom Jayne

(Continued from page 55)

away are the graves of two of his closest friends and colleagues—Dr. William Wallace and Dr. John Todd. The files at Oak Ridge Cemetery indicate the cause of death as “Heart.”

A great-grandson of Dr. Gershom Jayne, Mr. Louis P. Jayne, resides at 419 East Union Street, Springfield, Illinois. To the best of our knowledge, he is the only living descendant of the pioneer physician still living in Springfield. ◀

Floyd S. Barringer, M.D.

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## Apexcardiography

(Continued from page 40)

resembling a bulge. All four patients of Lane et al<sup>8</sup> had large left ventricular aneurysms. Although it is difficult to be certain, probably ventricular aneurysms were present in two of our patients as well, since both showed cardiac enlargement on chest X-ray. Rapid ballooning out of the thin fibrous wall of the aneurysmal left ventricle during diastole has been proposed as a mechanism for this change.

### Conclusion

Our study indicates that considerable changes in the apexcardiogram may be present long after recovery from acute myocardial infarction. Hemodynamic correlation of these suggest gross left ventricular dysfunction characterized by altered distensibility, contractility and disordered wall motion. In a similar study abnormal Kinetocardiograms were found by Schweizer et al in 80% of cases in patients with previous myocardial infarction. However, Kinetocardiography has not gained wider popularity and is not easily available. With proper attention to technical aspects, satisfactory apexcardiograms can be easily obtained.<sup>21</sup> Evaluation of status of the left ventricle is of obvious value in assessing long

term prognosis and management of these patients. We believe that this non-invasive technique of apexcardiography can be usefully employed for this purpose. Objective documentation thus easily obtained will supplement information provided by usual clinical examination. ◀

### References

A complete listing of references for this article may be obtained from the *IMJ*, 55 E. Monroe St., Room 3510, Chicago, 60603.

### Acknowledgement

The authors are indebted to Dr. Martin Brandfonbrener for his helpful advice and criticism. Thanks are due to M. Cotton for typing the manuscript.

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## Viewbox

(Continued from page 32)

**DIAGNOSIS: Reiters Syndrome**—This is a syndrome which occurs predominantly in young males and is associated with painful heels with shaggy reactive sclerosis of the entire os calcis. Clinically the syndrome is associated with urethritis, conjunctivitis, and a skin rash. The arthritis has a predilection for the weight bearing joints particularly the knees, ankles and small joints of the feet. Other than the fluffy reactive sclerosis of the os calcis, the changes are very similar to rheumatoid arthritis, psoriasis and ankylosing spondylitis. Changes may occur in the spine very similar to ankylosing spondylitis.

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## EKG

(Continued from page 44)

**Answer: 1. E 2. A,B**

The electrocardiogram shows ST segment elevation in II, III, and AVF and V<sub>1-5</sub>. This appears to be a normal variant and has been called the early repolarization syndrome. Review of previous tracings or serial electrocardiograms help distinguish this benign variant from acute injury current. This patient's history when obtained in greater detail was not suggestive of acute infarction but rather pointed to a noncardiac origin. Electrocardiogram taken two years prior was identical to the present tracing demonstrating the stable nature of the electrocardiographic abnormality. ◀



# Abdominal Aortic Aneurysm Surgery in the Jehovah's Witness

## Use of Auto Transfusion

BY MITCHEL P. BYRNE, M.D./EVANSTON

*Although greater numbers of abdominal aortic aneurysms are being surgically treated without blood transfusion, the elective treatment of an aneurysm in a Jehovah Witness who refuses transfusion is still a definite challenge. Today, heart surgery of all types is being done in these patients with use of cardio-pulmonary bypass. Interestingly the recirculation of the blood from the patient to the pump is quite acceptable to these patients. However, autotransfusion of pre-operatively stored blood is totally unacceptable. Recently this dilemma was solved when successful AAA resection and placement of a tube graft was carried out using the religiously acceptable technique of recirculation of all shed blood via a standard "heart lung" machine minus the oxygenator. Although this is generally considered autotransfusion, this term was avoided since the suffix "transfusion" would have made the technique unacceptable to this patient. Use of this technique resulted in an uneventful course for this Jehovah Witness.*

### Case Report

A 59 years old, white male presented to St. Francis Hospital with a history of post prandial abdominal pain which had increased on the morning of admission. The pain seemed to follow eating and was crampy in nature. There was no nausea or vomiting and no history of back pain or claudication.

Physical examination revealed a thin white male in no particular distress with a blood pressure of 200/130 and pulse of 80. A 10 cm abdominal aortic aneurysm was palpable extending from just below the xiphoid to the umbilicus. Lower extremity pulses were excellent throughout.

Initial laboratory evaluation revealed a hemoglobin of 15 gm, normal electrolytes, BUN 18, Prothrombin time 11.8 sec. Abdominal films confirmed the presence of a large abdominal aortic aneurysm.

### Abdominal Exploration

The morning following his admission the patient underwent abdominal exploration with the understanding that no autogenous blood or albumin would be used. Cardiac monitoring, CVP and radial artery pressures also were monitored. A large abdominal aortic aneurysm was found which compressed the duodenum. The aneurysm extended from just below the renal arteries to

just above the bifurcation. Proximal and distal control was obtained in a routine fashion. 7,500 units heparin were given systemically and an 18 mm woven dacron tube graft was inserted. The major blood loss was from four large actively bleeding lumbar arteries which were controlled with suture ligatures. During the entire procedure 2,000 cc of blood were aspirated via the cardiectomy suction utilizing the Olson Heart Lung machine and the Bentley cardiectomy reservoir. 5,000 units of additional heparin were added to the reservoir. An additional 2,500 cc of Ringers Lactate was also given during the operative procedure.

During surgery the patient received Keflin 2 gms, Lasix 20 mg. and Mannitol 25 gm., and  $\text{NaHCO}_3$  50 mg. I.V. push. Excellent arterial pressure, urine output and venous pressure were maintained during the procedure. Total operative time was 3½ hours. The patient's post operative course was essentially unremarkable. There was no gross evidence of hemolysis and no clinical abnormality of coagulation. His intravascular volume was maintained with Ringers Lactate. His hemoglobin dropped from 15.5 pre-op to 10.2 at the end of the procedure and was 7.0 three days post-op. From that point his hemoglobin made a slow recovery and was 14 gm one month post-op. IM Imferon was utilized for a few days after surgery. No blood or blood products such as albumin were used. The patient had a minor urinary tract infection, but at discharge, twelfth day post op he was fully ambulatory.

(Continued on page 90)

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MITCHEL P. BYRNE, M.D., is an Attending Surgeon at St. Francis Hospital, Evanston, and Clinical Instructor in Surgery at Loyola University Medical Center, Maywood.





# Testing in Humans: Who, Where & When.

## the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

**1.** PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

**2.** PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

**3.** When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

**4.** PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

**5.** PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

**6.** In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

**7.** PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

**8.** Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

**9.** Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

**10.** Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential

status as provided in codes of ethics governing health care professionals.

**11.** PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

**12.** PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

**13.** When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.



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### Discussion

Intraoperative autotransfusion has actually been available for over 100 years with the first reported case published by Highmore in 1874, in *Lancet*<sup>1</sup>. It was first used in the United States by Lockwood<sup>2</sup> in 1917, when he autotransfused 700 cc of blood obtained at the time of splenectomy in a patient with Banti's disease. These early attempts utilized sponging and ladling techniques until 1925 when Davis and Cushing<sup>3</sup> developed a more sophisticated method employing suctioning via the Bernoulli effect. From that point on autotransfusion has been used periodically during surgery for trauma, obstetrical emergencies, and cardio-vascular surgery.

Its use in surgical resection of diseased abdominal aorta (10 aneurysms, 10 occlusive cases) has been carefully evaluated by Darling<sup>4</sup> with favorable results in 20 patients. They concluded that autotransfusion provided a ready source of hepatitis free blood ideally suited for major vascular cases and trauma surgery. Four problem areas which occasionally arise were discussed: (1) hemolysis, (2) coagulation abnormalities, (3) microembolism, and (4) air embolism. Regarding *hemolysis*, it is pointed out that even the Roller pump used in their study and in our patient can cause red blood cell damage with resulting hemolysis. It has now been shown<sup>5,6</sup> that the free hemoglobin in itself is not harmful, but that the red cell envelopes are the factor in renal damage. In our patient there was transient hemoglobinuria but no evidence of renal impairment.

Darling demonstrated elevated free plasma hemoglobin in all patients with one-fourth of the patients having hemoglobinuria. There were no serious sequelae, however, and the plasma hemoglobin was normal in all patients within 24 hours. Darling also noted that in the absence of supplemental homologous transfusions, a drop in hematocrit post operatively always occurred. This was certainly the case in our patient with the hemoglobin dropping from 10.2 to 7.0 over three days. Darling concludes that this may be due to continuing hemolysis of damaged cells or plasma volume changes. It would not appear, however, to be a major problem.

### Possible Problems

*Coagulopathy*, although reported to be a problem in some series,<sup>7</sup> was not detected by Darling in their 20 cases, nor in our patient. Darling feels that large dose heparin therapy may prevent extra vascular consumptive coagulopathy. He noted extra vascular coagulation with doses of heparin below 100 units/kg. Our patient re-

ceived 7,500 units at the time the aorta was clamped and also had 5,000 units of heparin added to the pump. Thus the total heparin dose actually exceeds Darling's recommendations and probably helped prevent any significant coagulation changes.

*Microembolism* of platelet aggregates, fat, or other debris does not seem to be a serious problem. There is actually a double filtration system utilizing the autotransfuser filter plus a Swank type filter on the venous return line. Since there is undoubtedly debris, it is essential that a micro-pore "final" filter also be used in addition to the autotransfusion filter.

*Air embolism*, a potentially fatal complication, has been reported as a cause of death in two patients<sup>7</sup> having autotransfusion. The Bentley apparatus has a sensor device to detect volumes below 200 cc, however with layering out of thrombus on the sides of reservoir, the sensor unfortunately can be fooled and air embolism can occur. To avoid this, a pump technician should be in attendance with constant attention to the reservoir level to prevent any air entering the venous return line.

Autotransfusion would seem now to be a well established technique that is especially valuable in massively injured patients, major vascular cases, and also for Jehovah Witnesses such as the case presented. Although special autotransfuser units such as the Bentley are available, this case demonstrates how the usual pump oxygenator can readily be utilized with excellent results. ◀

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### Acknowledgements

My thanks to Mr. Robert Trapp for developing our modified autotransfuser for this patient.



# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ABINGDON:** Urgent need for FP/GP's. West-Central industrial/farming section. Educational, cultural, recreational environment. Join only physician in modern, well-equipped medical building. No investment. Future assured. Ten minutes to two new JCAH hospitals-470 beds. Convenient to medical centers. Available housing. Contact Ruth Bradway, Box 145, Abingdon 61410. PH: (309) 462-2120. (10)

**CARMI:** Three family physicians seek partner. Pleasant community of 6,200 in Southern Illinois. Drawing population 18,000. Office adjacent to fully accredited hospital. Partnership after one year. Call collect days: 618-382-8303; evenings 618-382-5041. (8)

**CHICAGO:** Comprehensive Health Care Center in the Metropolitan Chicago area has positions available for primary health care physicians. Center is located in close proximity to Community Hospital. Regularly scheduled hours. Financial arrangements will be discussed and will be commensurate with qualifications. Write or call: P. Pratscher, c/o Joliet Community Medical Center, 450 Prairie, Calumet City, IL 60409, Phone (312) 862-3100. (11)

**EDWARDSVILLE:** Well established General Practice with Surgery and OB-Gyn. available immediately to interested Physician. 25 min. to downtown St. Louis. New Community Hospital will open July 1st. Progressive town with Southern Illinois Univ. Campus. Recreational opportunities abound. Physician retiring. Contact: Ernst Linden, M.D., E. Lake Dr., Edwardsville, 62025, (618) 656-5199 (8)

**FOX LAKE:** Physician wanted to take over practice, equipment and medical building. Physician urgently needed in area. Convenient financial arrangements if necessary. Fifty (50) miles from Chicago in recreational area. Swimming, boating, fishing, hunting and winter sports. Contact: S. L. Fried, M.D., Box 116, Fox Lake 60020. (312) 587-5001. (10)

**ILLINOIS—**Physicians, Residents, Drug treatment clinics throughout the State need part-time (4-6 hrs. week) physicians' services. Compensation on a par with usual and customary local fee schedules, but negotiable upward with individual clinics. CONTACT: Mrs. Carmen Townsend, Illinois Dangerous Drugs Commission, 300 N. State, Suite 1500, Chicago 60610 (312) 822-9860 (8)

**JOHNSTON CITY:** Southern Illinois—population 4,000 near I-57. Family practice available. Full equipped office. Surgeon in clinic. Possible partnership available. Hospital 6 miles away. 20 miles to SIU. 100 miles to St. Louis Mo. Contact: Mrs. R. A. Rupprecht, 401 N. Allyn St., Carbondale, 62951 (618) 549-3093 (11)

**MT. STERLING,** Population 2200, County Population 5600. Only active MD in Brown County, age 73, wishes to cut back his work load. One 84 bed nursing home at edge of town, one 24 bed shelter care home in town. Nearest hospital, 82 bed capacity in Rushville, 17 miles away. Staff privileges available. 52 bed new hospital at

Beardstown, Ill, 21 miles. Courtesy staff privileges available. Two 200 plus bed hospitals in Quincy, Ill. 41 miles. Courtesy Staff privileges available. Illinois River 16 miles from town. Contact Raymond Bullard, 109 W. Main, Mt. Sterling, Ill. 62353 (217) 773-2144. (8)

**NEWARK—**Town Needs Physician - Complete office building, equipped, ready for use. Located in very stable farming community. Fine, well-equipped, modern hospital nearby. 65 miles S.W. of Chicago. Contact: Mrs. Victor H. Smith, Rt. 2, Box 148, Newark, Illinois 60541. Phone (815) 695-5119. (8)

**QUINCY:** Emergency medicine opening—rural mid-western atmosphere—Centrally located for outdoor recreation. Modern 280-Bed Hospital and Trauma Center. 2 M.D.'s looking for a partner or part-time Physician. Guarantee inc. and excellent schedule very flexible. Call collect or write, Thomas Fischer, M.D., Blessing Hospital, Quincy, 62301 (217) 223-5811. (11)

**ROBINSON:** Community of 8000 with remarkable economic balance of industry and agriculture. Two FP's, ages 38 & 34, urgently need an enthusiastic associate to join them in a well-rounded busy practice. Community Hospital. Multiple advantages. Junior college. CONTACT: Dean J. Pelley, M.D., Allen Clinic, Robinson, 62454, AC 618-544-3125. (8)

**ROCKFORD:** OB-GYN, Board Eligible or Certified. Will support for Solo Practice or Associate. Practice base in Catholic Hospital. Contact: John E. Tillis, M.D., 5670 East State Street, Rockford, 61108, Phone: (815) 398-4110. (11)

**SPRINGFIELD:** Two emergency physicians needed to supplement existing department in 650 bed community hospital with medical school affiliation. New emergency department facilities, 50,000 visits per year, excellent salary and fringe benefits, 40-44 hour week. Teaching position available if desired. Involvement with ongoing MERCI communications net and paramedic training program. Excellent opportunity to work, teach, and live in progressive midwest community with a metropolitan area of approximately 150,000. Contact E. W. Donelan, M.D., Chairman Emergency Services, St. John's Hospital, 800 East Carpenter, Springfield, 62702. 217-544-6464 (8)

**WAUKEGAN: MEDICAL DIRECTOR—**Johnson Outboards, an industrial firm employing 4,000 employees, is seeking a full-time occupational physician to direct the medical program at its Waukegan facilities. Responsibilities include the supervision of a medical staff consisting of eleven (11) nurses and a secretary; conducting pre-employment physicals as well as establishing medical and health policies. Liberal fringe benefits include life & health insurance, malpractice coverage, vacations, holidays & sick leave. Candidate must have a valid Illinois license. An equal opportunity employer. Salary is competitive. Contact Robert Engelhardt, Johnson Outboards, Waukegan, 60085. 312-689-6195. (8)

# Doctor—Your Opinion Please

The Illinois General Assembly recently enacted, and the Governor signed into law P.A. 79-1136. This bill mandates continuing medical education for medical license renewal. Forthcoming rules and regulations will specify specific requirements.

1) In light of this, are the opportunities for achieving CME credit available to you adequate?

YES \_\_\_\_\_ NO \_\_\_\_\_

Comment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2) Since the intent of the law is to improve patient care, please rank from best (1) the following means to achieve CME Credit which you think are most effective in maintaining your full clinical competence:

\_\_\_\_\_ National meetings of your specialty group.

\_\_\_\_\_ Formal CME courses at Illinois medical schools.

\_\_\_\_\_ Planned CME programs in your hospital.

\_\_\_\_\_ Earned CME credit as determined by routine medical audit required of hospitals.

\_\_\_\_\_ Scientific session by local medical society.

\_\_\_\_\_ Individualized personal learning program developed according to perceived need.

3) Do you feel mandatory CME will ultimately lead to identification of instances where practices should be modified or upgraded? YES \_\_\_\_\_ NO \_\_\_\_\_

Signed (optional) \_\_\_\_\_

County Medical Society \_\_\_\_\_

Return to: *IMJ* Survey  
55 E. Monroe St., Room 3510  
Chicago, Ill. 60603



# Illinois Foundation for Medical Care

## Division of Membership Services

### ACTIVITY REPORT

Since the report to the ISMS House of Delegates April 1976, IFMC's Division of Membership Services has been actively proceeding with the IFMC plan to assist individual physician members of ISMS with reimbursement problems they may have with the Illinois Department of Public Aid. The following report is being submitted outlining discussions and meetings held to date with the IDPA.

- In late April 1976, IFMC orally presented an overview of the IFMC Ambulatory Care Peer Review System to representatives of IDPA. During that meeting, it was mutually agreed that it would be necessary to conduct a test of the capabilities of the IFMC System. The test is scheduled for completion on June 25, 1976.
- In response to IFMC's request, IDPA has agreed to provide the Foundation with substantive and relevant data on fee levels so that meaningful discussions can begin on this issue.
- IFMC, on a continuing basis, is providing the Illinois House Subcommittee on Public Aid Reimbursements with progress reports on current discussions and meetings held with IDPA on IDPA's utilization of the IFMC Ambulatory Care Peer Review System, and the impact of IDPA's reimbursement policies on the quality of health care delivered to Medicaid recipients.

In addition to the above activities, the IFMC Division of Membership Services continues to assist individual physicians with specific reimbursement problems they may have with the Illinois Department of Public Aid. To date, 100 complaints have been received and appropriate action taken.

For further information, or assistance, contact:

Division of Membership Services  
Illinois Foundation for Medical Care  
55 East Monroe Street, Suite 3510  
Chicago, Illinois 60603  
(312) 236-0185

## GENERAL INFORMATION AND UPDATES

- IDPA's first set of revisions to their Physician's Handbook were mailed May 21, 1976. The following information should be noted:

- Beginning January 1, 1977, no physician bills will be accepted by IDPA which list services rendered 6 months prior to the bill submittal date. The Department will accept bills older than 6 months up through December 31, 1976.

- If an "old" bill has never been submitted, follow the usual procedure for submitting bills. If you have submitted bills and they have not been paid for 60 days, refer to pages 35-36 of the IDPA Physicians' Handbook for procedures to be followed.

- IFMC staff have found IDPA willing to process old bills which have been rejected or unpaid if there is documentation showing that the bills have been submitted previously. Such documentation includes:

1. The date stamped at the bottom of the rejected bill which shows dates previously submitted.
2. Form letters returned with rejected bills.
3. Voucher recaps showing bill delayed or rejected.
4. Other correspondence relative to specific bills.

- In order for physicians to be eligible for payment in the Medicaid program, they must be on IDPA's Provider File. Certain information is needed by IDPA

when a physician wishes to participate in the Medicaid program. This information includes:

1. Name
2. Address
3. AMA Medical Education Number
4. Social Security Number
5. County in which you practice

It takes approximately 1-2 weeks for participants to be added to the file.

No bills can be processed for payment until the above information is on file. If you wish to be added to IDPA's Provider File, call or write:

Provider Participation Unit  
Illinois Department of Public Aid  
Post Office Box 4034  
Springfield, Illinois 62708  
(217) 782-7087

- In the space labeled "Name and Address of Physician", lower left-hand side of DPA Form 132, IDPA requires the name and address of the physician who rendered the services to a Medicaid recipient. A stamp which lists only the name of the clinic and its address is *not* appropriate. If this procedure is not followed, IDPA may return your bills unpaid.

\* \* \* \* \*

## IFMC DIVISION OF MEMBERSHIP SERVICES—Booklet Update

- The following telephone numbers should be corrected in your IFMC Division of Membership Services booklet:

John Robertson — (217) 782-7088  
(incorrectly listed as 782-0497, pages 5, 6 and 7)

and

Paul Triyonis — (217) 782-0472  
(incorrectly listed as 782-0473, page 8)

- If the Division of Membership Services of the Illinois Foundation for Medical Care can be of assistance to you, contact:

ILLINOIS FOUNDATION FOR MEDICAL CARE

Division of Membership Services

55 East Monroe Street, Suite 3510

Chicago, Illinois 60603

(312) 236-0185



# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

### State Employees Program Renewed with Blue Cross and Blue Shield

Illinois Blue Cross and Blue Shield will again administer the health care program of more than 120,000 State of Illinois employees and their dependents for another year. The contract is effective July 1, 1976 through June 30, 1977. There have been no changes in the benefit structure of the program.

Because of the large number of employees and dependents protected, the scope of benefits of the program and the procedures on filing claims are reviewed in this issue of the *Blue Shield Report* as a service to physicians and their medical assistants.

#### Program Summary

Payment of employee claims is made on a Usual and Customary basis. The program incorporates co-insurance and deductible amounts at various levels. Options to cover dependents are provided at the same or reduced levels as employees and include the High Option Plan IIA; Low Option Plan IIB and IIC. Although the scope of benefit coverage is the same, payment levels are reduced, deductibles are increased and maximum payments lowered depending on the premium level of the plan selected by the employee.

Benefits of the High Option Plan II are summarized below:

#### PHYSICIANS' SERVICES:

- In-hospital professional services, including surgery, surgical assistance, anesthesia, care of fracture and complete dislocations;

- In-hospital medical care—365 days—including necessary consultations, intensive care, concurrent care, psychotherapy, inhalation therapy;

- Maternity care and obstetrical services;

- Home or office visits when related to an illness or injury that required hospitalization, up to a maximum of \$100 per person per contract year. Visits must be made within 90 days following hospital confinement.

(The above services are payable at 80% Usual and Customary for expenses up to \$1,000; 90% U & C for the next \$2,000 of expenses; 100% U & C for expenses over \$3,000).

- Emergency medical and accident care if treated within 72 hours. Coverage is 100% Usual and Customary with no limitation.

- Diagnostic services are covered at 100% Usual

and Customary up to maximum of \$600 per year per person, excluding professional fees.

- Routine home or office visits not covered unless \$200 of such charges for an individual in a contract year has been reached. Coverage then at 50% Usual & Customary charges, not including routine lab and X-ray.

- Out-patient mental and nervous care covered at 50% Usual & Customary charges not to exceed payment of \$25 per day.

- Obstetrical: Single female employees covered as well as female dependents. Early OB and Terminal OB (coverage for delivery so long as conception occurred while female was covered under the program). Normal newborn care covered while hospitalized.

#### Medical Expense Benefits

Prescription Drugs—outside the hospital: A \$50 per person per contract year deductible applies and payment from \$50-\$1,000 per person, per year at 80%; \$1,000-\$3,000 at 90% and expenses over \$3,000 paid at 100% per person, per year.

There is a \$50 deductible for other medical expenses. The following coverages and coinsurance variables also apply:

- Rental or purchase of iron lung or other durable medical equipment; prosthetic appliances including leg braces; physical therapy rehabilitative services; renal dialysis; expenses above the out-patient diagnostic allowances.

- Coinsurance Variables at 80% Usual & Customary for expenses up to \$5,000; 90% Usual & Customary for next \$5,000; and 100% Usual & Customary for expenses over \$10,000.

A special Medical Expense Benefit form must be used by state employees in filing their claims. Physicians enter the diagnosis, date of onset, first service, and sign the form.

Coordination of Benefits provisions apply throughout the entire program.

Coordination of Benefits with Medicare: Benefits will be paid up to the maximum prescribed for this program (or for whichever dependent option is selected), less those amounts paid by Medicare Parts A and B. (Blue Shield requires an Explanation of Medicare Benefits to pay its benefits).

(Continued on following page)

## State of Illinois Employees Program

(Continued from preceding page)

### Completing and Filing Claims

1) In completing the Blue Shield Physician's Service Report form for a State of Illinois employee or dependent, please use the Illinois Employees Group Insurance Program number 42500, and the employee's Social Security number. Do not use the patient's Social Security number unless the patient is the employee. To assure proper identification, ask the patient to present his Blue Shield State of Illinois Group Insurance Identification Card. The card will show the proper employee's Social Security number. If he does not have a card, please obtain this information before submitting the claim.

2) If you receive a "State of Illinois Department" inquiry form from Blue Shield with a Physician's Service Report attached, enter the Social Security number of the state employee on the form to which the billing refers. Please do not use the physician's Social Security number, nor the patient's (unless the patient is the employee). This will delay pay-

ment of the claim until the necessary employee Social Security number is received for identification.

3) There are no special forms or service reports to submit for the State of Illinois program. Please use the current Blue Shield Physician's Service Report form in submitting a claim.

### Send Claims to Proper Claims Center

For convenience in filing State of Illinois employee claims and to speed payments, two special Claims Centers serve the program exclusively.

Claims from the northern portion of the state including Cook and the counties south to Hancock, McDonough, Fulton, Tazewell, McLean, Ford and Iroquois should be mailed to the Chicago Claims Center, addressed to the Blue Shield Plan, 233 North Michigan Avenue, State of Illinois Department, 21st floor, Chicago, Illinois 60601.

Claims originating in downstate counties below a line including Adams, Schuyler, Mason, Logan, DeWitt, Champaign and Vermillion counties should be mailed to the Springfield Claim Center, addressed to Blue Shield Plan, 525 West Jefferson Street, Suite 207, Springfield, Illinois 62702.

## ASK BLUE SHIELD ... ABOUT MEDICARE

### Coverage of Services and Supplies Furnished by Nonphysician Employees

Payment is made for services and supplies furnished "incident-to" a physician's professional service in the Medicare program, when such services and supplies are provided as part of the physician's professional service in the course of diagnosis or treatment of an injury or illness. Services and supplies should be of the kind commonly furnished in the doctor's office or clinic and are either provided without charge or are included in the physician's bills. In private practice the services are limited to those furnished under a doctor's direct supervision.

In a recent clarification of coverage guidelines, the Social Security Administration emphasized: (1) ancillary personnel rendering the "incident-to" services should be those employed by the doctor to perform such services and be under his direct personal supervision, and (2) that supplies furnished should represent a cost to the physician in his practice. Both should be billed to the Medicare carrier as physician charges for in-practice professional services. Reference to the ancillary personnel was made for the services of nurses, nonphysician anesthetists, psychologists, technicians, therapists including physical therapists and other such assistants and aides.

Although direct personal supervision does not require that the doctor *must be present* when the

service is performed, he is expected to be in his office suite or nearby and available for direction and assistance if necessary. It is also expected that he rendered the initial service to the patient and that subsequent service reflects his active participation in, and management of the patient's course of treatment.

### Notification of Lab Withdrawals from Medicare Program

Notice was received from the Bureau of Health Insurance office, Social Security Administration, that the laboratories listed below are no longer participating in the Medicare program. No payment can be made after the effective date of withdrawal from the program.

Laboratory Associates, Inc.  
1200 North LaSalle Street  
Chicago, Illinois 60610

Provider Number: 14-8191  
Effective Date: May 19, 1976

PMD Clinical Laboratory  
2017 West 95 Street  
Chicago, Illinois 60643

Provider Number: 14-8150  
Effective Date: May 18, 1976



# Editorials



## This is My Side of the Street

Physicians often squabble as much as members of different labor unions in defining territorial rights and how far a physician can stretch his specialty without getting into the area of another specialist. This quarrel also extends into para-medical groups in their relationships with M.D.'s. The more people that get into the act the more problems we will have.

I recall when proctologists, who were M.D.'s but not board certified surgeons, limited their work to hemorrhoids, fissures, fistulas, pruritus ani and rectal polypi. Removing a malignancy of the rectum or lower colon was a no-no, especially if an abdominal incision was needed. This limitation held true in teaching hospitals but was adhered to less in community institutions. After all, the proctologist was licensed by the state to practice medicine and surgery.

As we become more and more specialized the chances of overlapping into other specialties increases. An argument appeared in the Question and Answer section of the *Journal of the American Medical Association*<sup>1</sup> recently, concerning the ethics involved in organizing a hospital conference on pneumonia. Should it be done by an internist, board certified in the sub-specialty of infectious diseases, or by a lung specialist. The question was referred to two consultants.

The first consultant suggested that the staff members involved read a volume of William Osler's, *Aequanimities* and learn from it what makes an institution thrive. In his opinion, "It raises the question of whether a physician is first a physician or whether specialization is the answer to all things." It depends upon whether

the physician is competent to well organize and conduct a conference on pneumonia.

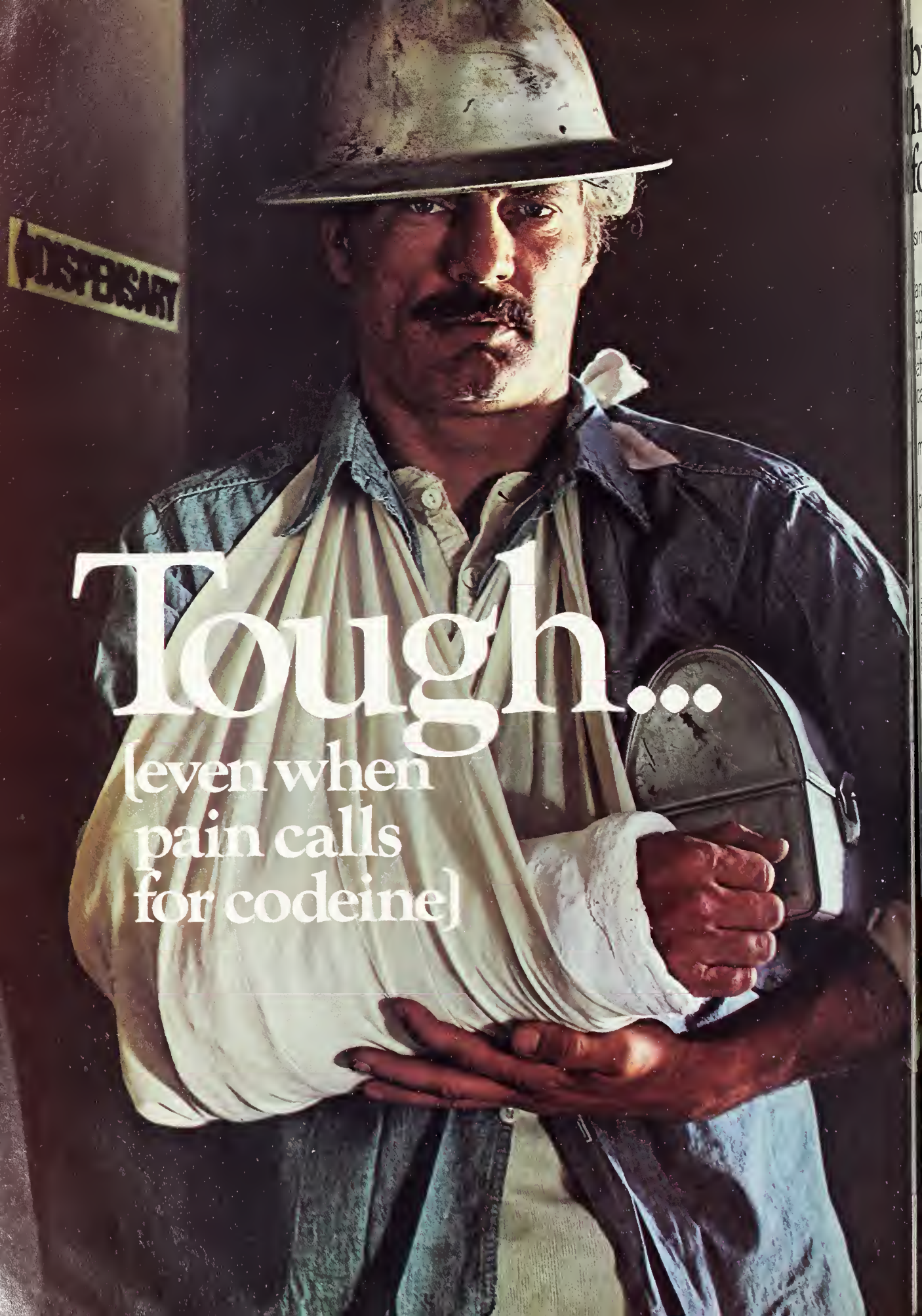
The second consultant said it was ethical for any specialist to schedule a discussion of any disease that was in or out of his specialty. But since pneumonia was a disease that falls within the scope of both specialists, the selection of the most appropriate antibiotic might be discussed by the specialist in infectious diseases and the management of complications such as hypoxia, pleural effusion or atelectasis could be discussed by the pulmonary specialist. This consultant (William R. Barelay) handled the question like a Solomon. But the first consultant (Theodore E. Woodward) stressed a point that deserves to be emphasized. We are all physicians and should be given credit for knowing a little something about all branches of medicine.

It is sad to note that in many hospitals and institutions the relationship between full time, teaching staff and clinical staff is not good. The practicing physician is so busy that he has little time for administrative duties. Many of these duties are passed to the full time staff which greatly improves his status. But the clinical staff provides the hospital with patients which is the main reason for its being in existence. Unless the clinical staff gets more recognition the end result may be comparable to killing the goose that laid the golden egg.

The alternatives are getting more obvious and I do not like them.

T. R. Van Dellen, M.D.  
*Editor*

1. *JAMA*, May 17, 1976, Vol. 235, pg. 2237.



DISPENSARY

# Tough...

(even when  
pain calls  
for codeine)



# But he may not have the stomach for APC.

Or the kidneys, for that matter.

Even bleeding time and platelet aggregation can be maximally prolonged by a single aspirin tablet.\*

We took that into account in revising the formula of Phenaphen® with Codeine, and combined codeine (in any of three different strengths) with acetaminophen to complement the codeine with little risk of APC complications. While there's no anti-inflammatory activity, there's no aspirin to aggravate G.I. problems or adversely affect bleeding time. Similarly, there's no potential renal risk from phenacetin, and no caffeine to stimulate patients unnecessarily.

There is the convenience of telephone Rx under Federal law...and the complementary analgesic efficacy of acetaminophen.

Phenaphen® with Codeine. Not just for patients who might have a "compound" problem, but for almost every patient who needs codeine. It's a lot simpler than APC.

## BRIEF SUMMARY

**Contraindications:** Hypersensitivity to acetaminophen or codeine.

**Warnings:** *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

*Usage in ambulatory patients.* Caution patients that acetaminophen and codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

*Interaction with other CNS depressants.* Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

*Usage in Pregnancy.* Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

**Precautions:** *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

*Acute abdominal condition.* Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

*Special risk patients.* Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

**Adverse Reactions:** Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

**Drug Interactions:** CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.



REVISED FORMULA  
**Phenaphen®**  
with **Codeine**  
**No.3** III  
Codeine Phosphate, USP-30 mg  
(Warning: May be habit forming)  
Acetaminophen, USP - 325 mg

to complement  
codeine with  
little risk of APC  
complications

\*Mielke, C.H., et al.: JAMA  
235:613 (Feb. 9) 1976.

**A-H-ROBINS**

A.H. Robins Company  
Richmond, Va. 23220

# Swine Flu Immunization Effort Begins

The ISMS Board of Trustees, at its recent meeting, urged all physician members and county medical societies to support the swine flu immunization program and cooperate with public health officials in implementing the plan in Illinois. The society believes this is an extremely worthwhile project which deserves the support of each and every physician.

Many physicians are concerned that the evidence for this kind of program is not as sound as would be desired. But to neglect to make the effort to use the scientific information at our disposal and to risk the morbidity and mortality experienced in 1918, 1957 and 1968 would be a serious mistake.

The swine flu immunization drive was scheduled to begin in late July. However, due to various problems surrounding the program, implementation will probably not begin until late September. A major issue in implementing the program has been the question of the physician's exposure to liability through participation in the immunization effort. To meet this concern the following solutions are being examined:

- Each person receiving the vaccine may be required to sign an informed consent form developed by IDPH, after being counseled.
- Insurance issued by the Illinois State Medical Inter-Insurance Exchange will cover physicians' participation in the program.
- Current Illinois law (Chapter 85, section 104) protects public employees from liability. Volunteers (physicians) with the swine flu program will be considered public employees.
- The federal tort liability act may make the federal government liable for any suits arising as a result of this program.

More than 11 million doses of vaccine were ordered by the Illinois Department of Public Health and the Chicago Department of Health which are coordinating the effort. Programs in suburban Cook County and downstate will be implemented by local health departments. In those areas without local health departments, the Board encourages county medical societies to offer their support to county boards in planning, promoting and implementing the program. Upon

request, ISMS is presently providing assistance through its field service representatives to those societies which do not maintain full-time staffs.

Because of time constraints, most people will have to be immunized at mass clinics. Therefore the Board encourages physicians to: 1) volunteer their services to work as supervisors at the mass clinics; and 2) encourage all ambulatory patients—including those in the high-risk category—to obtain their immunization at mass clinics.

There are three phases to the Implementation Plan for Illinois. The first phase will focus on immunization of high-risk patients who will receive bivalent vaccine containing both A/Victoria/75 and A/New Jersey/76 strains. The high-risk group is persons of all ages with such chronic health problems as: 1) heart disease of any etiology, particularly with mitral stenosis or cardiac failure; 2) chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, cystic fibrosis, bronchiectasis, TB, and emphysema; 3) chronic renal failure; 4) diabetes mellitus and other metabolic disorders; and 5) all persons over age 65 years. Local health departments or the designated agency of the county will determine if physicians will be provided bivalent vaccine and equipment for immunizing high-risk patients in their practice. High-risk patients residing in nursing homes will be immunized by the facilities' own staffs upon approval of the individual's personal physician.

The second phase of the plan is intended to immunize the general population with monovalent vaccine containing only the A/New Jersey/76 strain. A concerted effort to vaccinate all persons not previously immunized will be made in the third phase, beginning in November. During this final phase physicians may be able to receive vaccine and equipment from their county designated agency to vaccinate those patients who would rather receive the immunization from their personal physician.

Although physicians cannot charge for vaccine and equipment supplied by public health authorities, the ISMS Board maintains it is appropriate for physicians to charge their usual, customary and reasonable fee for administering the vaccine. ◀





WALLACE LABORATORIES  
Division of Carter-Wallace, Inc.  
Cranbury, New Jersey 08512

# The promise of Soma in the "low-back" patient: relief of discomfort... improved function

In 3 double-blind, randomized, placebo-controlled studies<sup>1-3</sup> of patients with acute, painful musculoskeletal disorders affecting the back, Soma helped effect...

- significant relief of discomfort, stiffness and other symptoms
- significant improvement in range of motion as measured by objective tests of function.

Add Soma to your standard regimen for low-back disorders...and, if necessary, add your choice of analgesic. Then let your patient report the results.

In acute, painful low-back disorders

## **Soma<sup>®</sup> 350** (carisoprodol) 350 mg tablets for measurable relief

**Indications:** Carisoprodol is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.

**Contraindications:** Acute intermittent porphyria and allergic or idiosyncratic reactions to carisoprodol or related compounds such as meprobamate, mebutamate, tybamate.

**Warnings:** *Idiosyncratic Reactions:* Rarely, extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion and disorientation have appeared within minutes or hours of the first dose.

These usually subside in several hours but supportive and symptomatic therapy, including hospitalization, may be necessary.

*Pregnancy and Lactation:* Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers (concentrations in breast milk are two to four times that in plasma), or women of childbearing potential.

*Children Under Twelve:* Not recommended.

*Potentially Hazardous Tasks:* Driving a motor vehicle or operating machinery.

*Additive Effects:* Effects of carisoprodol and alcohol, other CNS depressants or psychotropic drugs may be additive.

*Drug Dependence:* Use cautiously in addiction-prone patients.

**Precautions:** To avoid excess accumulation, use caution in patients with compromised liver or kidney function.

**Adverse Reactions:** *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia, idiosyncratic reaction (see "Warnings").

*Allergic or Idiosyncratic:* In previously unexposed patients, these are usually seen after 1-4 doses and include rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction to meprobamate. Asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension and anaphylactoid shock may be manifestations of severe reactions. In such cases, stop carisoprodol and initiate appropriate treatment (e.g., epinephrine, antihistamines, corticosteroids).

*Cardiovascular:* Tachycardia, postural hypotension, facial flushing.

*Gastrointestinal:* Nausea, vomiting, hiccup, epigastric distress.

*Hematologic:* Leukopenia and pancytopenia (on carisoprodol plus other drugs).

**Usual Adult Dosage:** One 350 mg tablet three times daily and at bedtime.

**Overdosage:** Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdosage of carisoprodol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

**Before prescribing, consult package circular or latest PDR information.**

1. Hindle, T.H. III: Calif. Med. 117:7 (Aug.) 1972. 2,3. Unpublished Data on file, Medical Department, Wallace Laboratories, Cranbury, N.J.

## The New Health Planning Law

We physicians can be so absorbed by our day-to-day problems that we overlook a danger now building up—a danger that could compound many problems and create new ones.

It's the Health Planning Act of 1974 (P.L. 93-641). This law is not just another governmental abstraction. It's the framework for a bureaucratic totalitarianism that could reshape the health-care system—including the responsibilities and expandability of hospitals and other facilities and even the rates they charge.

Moves to put doctors' offices and fees within the scope of the act are afoot in the Department of HEW, even though the AMA got them excluded from the law.

Certainly there must be planning to avoid costly overbuilding and overstocking of hospitals. Consider some of the ways, however, in which the Health Planning Act would flout the principles of rational planning, be a heavy expense in itself, and imperil the quality of care.

- The Secretary of HEW is to dominate five overlapping levels of federal, state and local authority. He will issue national health planning policy; appoint a national advisory council; approve state and local planning agencies and the funds they receive, and

establish the criteria and procedures they use.

- Certificate-of-need legislation must be adopted in all states, as prescribed by the HEW Secretary. The need for all new institutional facilities and services must be certified; the need for all existent institutional services must be reviewed every five years. Practice-profile data from PSROs, plus the minority status of direct providers of care on local planning boards, could arbitrarily influence the expansion or continuation of services.

- Up to six states are to get federal grants to demonstrate rate regulation for health services. This could become mandatory for all states and encompass physicians. Regulation is likely to result in an obsession with cost at the expense of high-quality care.

The AMA has petitioned federal court to join the State of North Carolina in a suit aimed at voiding the law. But adjudication can take months. Meanwhile, physicians in many parts of the country are seeking adequate representation on local planning boards and showing up at public hearings pursuant to the law. For the moment there is no other game in town. ◀

## Clinics for Crippled Children Listed for September

Thirty two clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty three general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be seven special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

September 1 Hinsdale, Hinsdale Sanitarium  
 September 2 Sterling, Community General Hospital  
 September 2 Effingham, St. Anthony Hospital  
 September 2 Lake County Cardiac, Victory Memorial Hospital  
 September 8 Joliet, St. Joseph's Hospital  
 September 8 Champaign-Urbana, McKinley Hospital  
 September 9 Macomb, McDonough District Hospital  
 September 9 Springfield, St. John's Hospital  
 September 9 West Frankfort, Union Hospital  
 September 10 Chicago Heights Cardiac, St. James Hos.  
 September 10 Division Cardiac, U. of Illinois Hospital, Center for Handicapped Children  
 September 13 Peoria Cardiac, St. Francis Children's Hos.  
 September 14 Peoria, St. Francis Children's Hospital  
 September 14 Carrollton, Boyd Memorial Hospital  
 September 14 Carmi, Carmi Township Hospital  
 September 14 E. St. Louis, Christian Welfare Hospital  
 September 15 Centralia, St. Mary's Hospital  
 September 15 Evergreen Park, Little Company of Mary Hospital

September 15 Rock Island Cerebral Palsy, Foundation for Crippled Children and Adults

September 16 Rockford, Rockford Memorial Hospital  
 September 16 Elmhurst Cardiac, Memorial Hospital of DuPage County

September 21 Rock Island, Moline Public Hospital

September 21 Belleville, St. Elizabeth's Hospital

September 21 Decatur, Decatur Memorial Hospital

September 22 Springfield-Pediatric Neurology, St. John's Hospital

September 22 Anna, Union County Hospital

September 22 Chicago Heights, St. James Hospital

September 22 Elgin, Sherman Hospital

September 24 Chicago Heights Cardiac, St. James Hospital

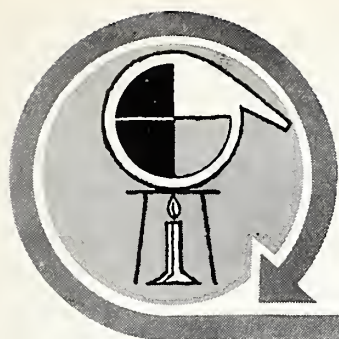
September 27 Peoria Cardiac, St. Francis Children's Hos.

September 28 Peoria, St. Francis Children's Hospital

September 28 Alton, Alton Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on behalf of crippled children.





# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

The following new drugs have been marketed:

## NEW SINGLE DRUGS

### NALFON Antiinflammatory Agent Nonhormonal Rx

**Manufacturer:** Dista Products  
**Nonproprietary Name:** Fenoprofen Calcium  
**Indications:** Relief of the signs and symptoms of rheumatoid arthritis.  
**Contraindications:** Do not give to patients in whom aspirin or other nonhormonal antiinflammatory agents produce asthma, rhinitis or urticaria.  
**Dosage:** Initial—600 mg. four times daily, adjust to patient's response. Given 30 minutes before or 2 hours after meals.  
**Supplied:** Capsules, 300 mg.

### NAPROSYN Antiinflammatory Agent Nonhormonal Rx

**Manufacturer:** Syntex Corporation  
**Nonproprietary Name:** Naproxen  
**Indications:** Relief of the signs and symptoms of rheumatoid arthritis.  
**Contraindications:** Do not give to patients in whom aspirin or other nonhormonal antiinflammatory agents produce asthma, rhinitis or urticaria.  
**Dosage:** One tablet morning and evening; do not give more than 750 mg. daily.  
**Supplied:** Tablets, 250 mg.

## DUPLICATE SINGLE DRUGS

### GENISIS Hormones Estrogens Rx

**Manufacturer:** Organon, Inc.  
**Nonproprietary Name:** Conjugated estrogens  
**Indications:** Replacement therapy in conditions caused by estrogen deficiency.

**Caution:**

**Dosage:**

**Supplied:**

### GRIS-PEG

**Manufacturer:**  
**Nonproprietary Name:** Griseofulvin, ultramicrosize  
**Indications:** Ringworm and fungal infections.  
**Contraindications:**

**Dosage:**

**Supplied:**

### HEPRINAR Inj.

**Manufacturer:**  
**Nonproprietary Name:** Heparin Sodium Inj.  
**Indications:**

**Contraindications:**

**Dosage:**

**Supplied:**

### SYNEMOL

**Manufacturer:**  
**Nonproprietary Name:** Fluocinolone Acetonide  
**Indications:**

**Contraindications:**

**Administration:**

**Supplied:**

### THEOCLAIR

**Manufacturer:**  
**Nonproprietary Name:** Theophyllin  
**Indications:**

Refer to package insert.

Varies with severity of symptoms, ranging from 1.25 mg. to 3.75 mg. daily.

Tablets, 0.625; 1.25 and 2.5 mg.

### Fungicide-Systemic Rx

**Dorsey Laboratories**  
Griseofulvin, ultramicrosize  
Ringworm and fungal infections.  
Porphyria and hepatocellular failure.

**Adults:** 250 mg. daily. **Children:** Approximately 5 mg/kg of body weight a day.

Tablets, 125 mg.

### Anticoagulants Rx

**Armour Pharmaceutical Co.**  
Heparin Sodium Inj.

Anticoagulant therapy in prophylaxis and treatment of venous thrombosis and pulmonary embolism and related conditions. Inability to perform suitable blood coagulation tests; uncontrollable bleeding.

**Deep sc injection;** intermittent iv injection or intravenous infusion. Adjust to patient's coagulation test.

Vials, 1,000, 5,000 and 10,000 U/ml.

### Local Corticoid Rx

**Syntex Laboratories, Inc.**  
Fluocinolone Acetonide  
Inflammatory manifestations of corticosteroid responsive dermatoses.

**Vaccinia and varicella**  
Open therapy: Apply three or four times daily. Occlusive dressing: Leave visible coat on surface and cover with nonporous film.

Tubes and jars, cream 0.025% and 0.01%

### Bronchodilator Rx

**Riker Laboratories, Inc.**  
Theophyllin  
Symptomatic relief of bronchospasm associated with acute

asthma, chronic bronchitis and emphysema.  
 Dosage: Three tablets initially and then one to two tablets every six hours on an empty stomach.  
 Supplied: Tablets, 125 mg.

#### COMBINATION PRODUCTS

**EXZIT** Emollient o.t.c.  
 Manufacturer: Dome Laboratories  
 Composition: Colloidal Sulfur  
 Resorcinol monoacetate  
 Indications: Drying and peeling blemishes in acne and related skin conditions.  
 Administration: Wash affected areas, then dry and apply twice daily.  
 Supplied: Creme, tubes, 1 oz.  
 Lotion, bottles, 2 fl. oz.

**EXZIT Cleanser** Dermatological cleanser o.t.c.  
 Manufacturer: Dome Laboratories  
 Composition: Colloidal Sulfur  
 Salicylic acid  
 Indications: Aid in the treatment of acne.  
 Administration: Apply twice daily, morning and bedtime.  
 Supplied: Jars, 4 oz.

**H Q C Kit** Dermatologic Preparation Rx  
 Manufacturer: Paul B. Elder Company  
 Composition: Each tube: Hydroquinone 4%, velvet cream base  
 Each tube: Hydroquinone 4%, opaque base  
 Each tube: Hydrocortisone 1%, cream base  
 Indications: Pigmented skin blemishes.  
 Dosage: Three steps to be followed, see package insert.  
 Supplied: Three tubes.

#### NEW DOSAGE FORMS

**ARISTOCORT** Local Corticoid Rx  
**A Cream**  
 Manufacturer: Lederle Laboratories  
 Nonproprietary Name: Triamcinolone Acetonide  
 Indications: Inflammatory manifestations of corticosteroid responsive dermatoses.  
 Contraindications: Vaccinia and varicella  
 Administration: Apply to affected areas three or four times daily.  
 Supplied: Tubes, 15 and 75 Gm., cream 0.1%

**BRETHINE** Bronchodilator Rx  
 Manufacturer: Geigy Pharmaceuticals  
 Nonproprietary Name: Terbutaline Sulfate  
 Indications: Bronchial asthma and reversible bronchospasms occurring with bronchitis and emphysema.  
 Contraindications: Known hypersensitivity to sympathomimetic amines.  
 Dosage: 0.25 mg. subcutaneously into the lateral deltoid area; additional doses according to package insert.  
 Supplied: Ampules, 2 ml. ml/1 mg.

**GYNE-LOTTRIMIN** Topical Fungicide Rx  
 Manufacturer: Delbay Pharmaceuticals, Inc.  
 Nonproprietary Name: Clotrimazole  
 Indications: Vulvovaginal candidiasis.  
 Dosage: 1 tablet per day for seven consecutive days, inserted intravaginally, preferably at bedtime.  
 Supplied: Vaginal Tablets, 100 mg.

**KEFLEX Tablets** Antibiotic Rx  
 Manufacturer: Eli Lilly & Co.  
 Nonproprietary Name: Cephalixin  
 Indications: Respiratory and urinary tract infections, otitis media, skin and soft tissue infections caused by susceptible organisms.  
 Contraindications: Sensitivity to penicillin and cephalosporins.  
 Dosage: Adults; 1 to 4 Gm. daily in divided doses. Children; see package insert.  
 Supplied: Tablets, 1 Gm.

**PROGESTASERT** Hormones Progesterone  
**System** Contraceptive Rx  
 Manufacturer: Alza Pharmaceuticals  
 Nonproprietary Name: Progesterone Intrauterine contraceptive system.  
 Indications: Contraception.  
 Contraindications: Pregnancy or suspicion of pregnancy. For others, refer to package insert.  
 Dosage: Insert device into uterine cavity once a year.  
 Supplied: Tubular vertical stem, 38 mg.

**TRIDESILON** Local Corticoid Rx  
**OINTMENT**  
 Manufacturer: Dome Laboratories  
 Nonproprietary Name: Desonide  
 Indications: Inflammatory manifestations of corticosteroid responsive dermatoses.  
 Contraindications: Vaccinia and varicella  
 Administration: Apply thin film two or three times daily.  
 Supplied: Tubes, 15 and 60 Gm., ointment, 0.05%

**UVAL Sun 'N Wind Stick** Emollient and protective Rx  
 Manufacturer: Dome Laboratories  
 Nonproprietary Name: Sulisobenzone  
 Application: Apply as needed.  
 Supplied: Sticks in dispenser pack.

**TYLENOL W/ CODEINE ELIXIR** Analgesic Rx  
 Manufacturer: McNeil Laboratories, Inc.  
 Composition: Codeine phosphate, 12 mg.  
 Acetaminophen, 120 mg.  
 Alcohol, 7%/5 ml.  
 Indications: Pain requiring enhanced analgesia.  
 Dosage: Adults, 1 tablespoon 4 times daily. Children. 7-12 yrs., 2 tsp 3 to 4 times daily.  
 Supplied: Elixir



For lungs that need  
all the help you can give them  
in chronic bronchitis/emphysema  
**Bronkotabs®**

ephedrine/theophylline/glyceryl guaiacolate/phenobarbital



Potent bronchodilation and rapid reduction of bronchial edema open constricted airways for easier breathing.

Efficient expectorant action thins and loosens tenacious mucus to facilitate its removal.

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*Helpful addition to an aggressive management program*

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**PRECAUTIONS:** With Bronkotabs therapy sympathomimetic side effects are minimal. However, frequent or prolonged use may cause nervousness, restlessness, or sleeplessness. Bronkotabs should be used with caution in the presence of hypertension, heart disease, or hyperthyroidism. Drowsiness may occur. Ephedrine may cause urinary retention, especially in the presence of partial obstruction, as in prostatism.

**RECOMMENDED DOSAGE:** One tablet every 3 or 4 hours, not to exceed five times daily. Children over 6: one half adult dose.

**SUPPLIED:** Bottles of 100 and 1000 scored tablets

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# Medical Excellence in Illinois

(Rockford in particular)

## Why?

BY HUGH A. JOHNSON, M.D./ROCKFORD

*"A Socialist's belief is that nothing matters as long as misery is shared."*

WINSTON CHURCHILL

All experiments at socialism or communism from Oneida on have failed, and each new try seems to soon reach the same totalitarian end. In the meantime, our successful experiment in private enterprise continues to prosper and to improve the lot of man. It prospers so well, in fact, that some citizens feel guilty and seem to want to share the misery of the socialists as the gap widens. The worst-off of our loafers—alcoholics, borderline, non-committable psychotics, motivational drug users, etc.—have at their disposal social services far beyond the average Soviet citizen. Why do the muddle-heads want to trade our system for another?

Our system has achieved so much, but only by competition. The fittest institutions survive. Of course there is waste in the failure and weeding out of the ne'er-do-well institutions. If this weeding did not take place we would have catgut sutures such as they have in the U.S.S.R. There one company makes all the sutures, and every year they get worse. On my first visit Russian catgut was like grocery-store string. It now approaches binder twine in size (but not strength). The gut is so poor that its use is avoided whenever possible.

Competition and natural selection, i.e. survival of the fittest, is a natural law with which we can't tamper. If we do, we're in trouble—as rabbits and

myxomatosis in Australia, price controls, starlings and English sparrows, a punitive income tax discouraging venture capital, legislating medical care and other human behavior.

In Rockford we have three excellent hospitals with hospital staffs equal to and often better than any others in the country. Each hospital, for literally generations, has been trying to outdo the others in giving better medical care. In this refinement process there has been reduplication and waste. A necessary waste, however, for remember when a salmon lays a million eggs only a few superior eggs survive and become adult fish to return again to the mountain stream.

Though I no longer do so, it was a joy to do surgery in the three Rockford hospitals, to see three different operating crews trying to be the best in town. But now the planners, those non-medical interlopers who still hang onto their tattered dream of the perfect socialist state (or whatever they wish to call it), wish to regulate away this wasteful competition, to regulate Rockford's medical centers into mediocrity. Just think, the draft horse could have been saved by these planners. All that waste of good horseflesh could have been prevented if they could have regulated the motor trucks. (On second thought, what peace to get rid of those semis—no, it wouldn't work on the motorways.)

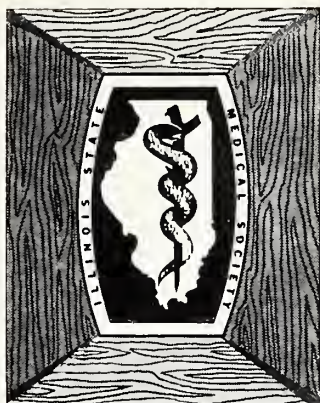
If we are going to continue to better things, hospital boards must act quickly. Hospitals must continue to meet the needs of their staffs before present controls become frozen in law.

No one can improve on Churchill, but I might try to paraphrase. If hospital care in Illinois is to advance we must ignore those who would control and legislate it and proceed on our own competitive, and to date, successful way. "It is the socialist's belief that nothing matters as long as mediocrity is achieved."



HUGH A. JOHNSON, M.D., is in the private practice of plastic and reconstructive surgery in the Rockford Memorial Medical Building at the Rockford Memorial Hospital. He also maintains an office at Northwoods Hospital, Phelps, Wisconsin. Dr. Johnson is on the active staff of both Rockford Memorial Hospital and Northwoods Hospital, and is a consultant to the Sumner Kach Burn Unit at Cook County Hospital, Chicago.





# I M J

Illinois Medical Journal

Vol. 150, No. 2, August, 1976

## Psychosocial Evaluation of the Cancer Patient

BY EDWARD WASSERMAN, M.D./CHICAGO

*Cancer is an illness which severely strains the psychological and emotional resources of patient, family and treatment team. In order to make the best use of these resources, a psychosocial evaluation is in order, preferably early in the illness. The evaluation can be done by the primary care physician, if he is willing to make the necessary observations, to do some thinking about the situation, and to request help when indicated.*

Every aspect of the clinical approach to patients can be a part of the psychosocial evaluation, provided that the physician is able to conceptualize it that way. For example, in a recent psychosocial case presentation, the presenting physician omitted mention that the patient had refused a rectal exam, but had later permitted another doctor to do it. The presenter could not see the important connections between the patient's non-complaint behavior, the medical-psychological problems and his own important omission in giving the history. In another fairly frequent clinical situation, a physician observed in an informal aside during rounds that his approach to the patient might not be so objective since his personal feelings about the patient were very strong. A frank, private discussion after rounds and a bedside consultation with the patient helped to restore perspective. Such experiences with patients can and should be considered as valuable psychosocial information.

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EDWARD WASSERMAN, M.D., is Assistant Professor of Psychiatry at Northwestern University Medical School. He is also a consultant to Jewish Family Service and the American Cancer Society's Reach-to-Recovery Program; Clinical Associate and Workshop Coordinator for the Institute for Psychoanalysis; and an Examiner on the American Board of Psychiatry.

A comprehensive medical-psychological approach can be practiced, taught and learned. An excellent description of such an approach has been written by Engel and Morgan.<sup>1</sup>

### Patient-Centered Evaluation

The patient-centered portion of the psychosocial evaluation is obtained primarily from history taking, and if necessary from collateral sources. The combined medical and psychosocial history gathers data about intelligence, mental status, level of insight, coping style, psychological defenses, affect, level of physical and emotional pain, and stage in the working through (or grieving) process.

Often we can satisfy ourselves regarding the patient's intellectual level by observing and making inferences from the patient's vocabulary and capacity to grasp unfamiliar facts. If we notice discrepancies or paradoxes in the patient's verbalizations, we may choose to test hypotheses by asking more sophisticated questions designed to elucidate. The formal mental status exam as part of medical work-up is often cursory and consists of asking the patient to subtract serial sevens, the name of hospital, time, etc. This will screen out gross sensorial defects; with some training a more subtle examination can be done.

Evaluating the adaptive and coping mechanisms is a challenging task requiring sophistication. Every physician is aware of the frequently observed psychological defense mechanisms such as denial, repression, apathy or withdrawal. Psychiatrists and psychoanalysts deal with ego processes almost exclusively but not always in situations of gross stress. Understanding people under a variety of immense and unusual stresses can give useful insight into the everyday clinical situation. Dimsdale<sup>2</sup> and Hamburg<sup>3</sup> have recently written about ways of evaluating, coping and adaptation; i.e., the way the mental apparatus processes stress.

### Coping with Stress

Dimsdale studied a group of concentration camp survivors without major psychiatric sequelae. Each interview lasted from two to eight hours per person. Dimsdale asked himself while listening to the taped interviews, how did the survivor cope? He noted categories of styles as listed in Table I.<sup>2</sup>

Most people used more than one mechanism to cope with stress. These listed roughly in decreasing order of effectiveness as survival techniques. Such categorization may be crude and incomplete, at this stage of our knowledge but it helps to limit and define the problem. What can be done to interfere with a maladaptive coping style?

**Table I—Coping Styles**

Differential focus on the good  
Survival for some purpose  
Psychological removal, including intellectualization, belief in immortality, time focus, humor, and "musselmann"  
Mastery  
Will to live  
Hope—active and passive  
Group affiliation  
Regressive behavior  
Null coping—fatalism  
Anticoping—surrender to stress

It has been demonstrated time and again that in situations of extreme stress, coping mechanisms become vulnerable even in the healthy, young adult unless supports are available. For example, during WW II younger merchant seamen who were torpedoed and adrift in the Atlantic did poorly while older seamen survived better. What were the relevant factors? Once these were defined, a survival training program was set up to teach rational survival techniques and to create an optimistic attitude about the possibility of survival. These psychological principles are now incorporated into military survival

training programs and into the Destination Outbound Camps.

It is very probable that each of the coping styles listed by Dimsdale can be supported or altered, depending on how adaptive they are to the stressful situation. We are all familiar from clinical experience with patients who exhibit what Dimsdale calls "null coping" and "anticoping". These mechanisms are similar to what Engle and Schmale<sup>4</sup> have termed the "giving-up, given-up" complex. There is some evidence to support the notion that bodily defenses against illness and psychological defenses against painful affective states are inter-related. Corticosteroid levels in parents of very sick children with leukemia showed parallels between the mental-emotional state of the parent under stress and their corticosteroid levels. Studies of psychological defense mechanisms in some chronic illnesses such as brucellosis and infectious mononucleosis have shown positive correlations between measurable ego-strength and reduced chronicity. Laboratory studies of primates and other animals under stress support this idea.<sup>5</sup>

### Coping Styles in Clinical Situations

Clinical situations can also be evaluated for coping style and intervention method, as in the following anecdote.

A woman with far advanced ovarian carcinoma had been gradually losing weight. She visited her children and grandchildren on a pass from the hospital on weekends. She said, "I have to make it to the weekend, it's my grandchild's birthday." She was discouraged that she had not gained weight. Minor change in the diet and palliative regime were recommended and emotional support offered. On the next "rounds" she announced triumphantly a gain of one pound; she was congratulated. The weekend birthday party was a success; the next week she found another short term goal.

The patient exhibited a number of coping mechanisms. She "focused on the good", she had a purpose to survive, active hope, and the will to live. Her discouragement did not give way to fatalism or surrender. She accepted palliative treatment as both physically and psychologically strengthening and gave us gratification in return. This patient managed to find some daily short-term goal until shortly before her death. She was obviously sensitive and vulnerable to her treatment and family milieu. What would have hap-



pened if the physician, hospital or family were not so supportive?

### Complications

Senescu has described frequently observed complications found in cancer patients, many of which are emotional reactions to a changing and stressful reality to which the sick patient must adapt. He carefully documents examples of excessive dependency with concomitant emotional and intellectual regression or the use of the illness by the patient for secondary gain. There frequently are feelings of damage and reduction of self-esteem, with associated anger, guilt and depression or feelings of loss of pleasure and gratification. The patient may react vigorously to some of the physician's attitudes, or to events in the family and hospital.

It is important to evaluate the patients' emotional responses and particularly the level of depression. Is it an understandable transitory reaction to the illness, or has the depression reached clinical proportions, necessitating psychiatric attention?

Pain and emotional reactions to pain may be the central problem to which the patient is attempting to cope. Careful evaluation of the pain and pain control is necessary. Usually when the patient feels secure that his pain will be adequately controlled, i.e., when there is a situation of basic trust between patient and treatment team, many reactive emotional complications can be prevented or ameliorated. Marks and Sacher<sup>7</sup> showed that house-staff physicians often have apprehension and misunderstanding about the use of narcotics. They frequently underdose, due to unrealistic fears of creating respiratory problems or addiction. The use of PRN orders is frequently ineffective. Too many variables come into play; anxieties in patient and staff are aroused, increasing rather than decreasing the need for medication. Housestaff and students need careful bed-side training about the use of narcotics.

### Signals for Psychotherapy

Some sadness and depression are ordinary concomitants of any chronic or life-threatening illness. In the early stages, the threat of loss of function, loss of body part or loss of life itself is usually associated with normal grieving. Sadness, crying, some loss of appetite or insomnia may occur. As in any grieving process, the love

and attention of concerned relatives mitigate the loss. The physician can offer his emotional support to patient and family as well as practical remedies such as sleep medication when needed, changes in diet, control of odors in hospital rooms and noise control. When grief reactions are prolonged, excessive or conspicuously absent, one should consider referral for psychotherapy and the use of anti-depressants. The important indicative signs are anorexia and weight loss which can not be explained by the organic illness, agitation or psychomotor retardation and insomnia. If the patient expresses suicidal preoccupations they should be evaluated, particularly if there is *intention* or *method* mentioned or hinted. There is no danger in exploring for suicidal ideas; experience teaches the opposite—failing to ask is far more risky.

The consulting psychiatrist must attempt to carefully pinpoint the reason the patient is reacting. It may not be the illness per se but renewed fear of pain, mutilation or separation from loved ones which is causing the most distress. Differentiation by the clinician may make the supporting task more effective. From a more detailed interview we attempt to determine what attitude the patient has about the illness and how far along they are emotionally. Kübler-Ross<sup>8</sup> has listed frequently found stages of adaptation to advanced and terminal cancer patients. She mentions denial, questioning fate, anger, bartering, acceptance, depression and resignation as regular stages in the grief process.

In the patient with relatively good prognosis the denial stage is often adaptive and does not interfere with the patient's ability to intellectually (but not emotionally) understand the seriousness of the illness. Denial is not the same in every personality and reflects very much the usual style in which psychic pain is processed or fractionated by the healthy ego. The clinician can work with these phases, but should not undercut important defenses if the patient is cooperative and comfortable. Defenses are judged maladaptive when they result in non-complaint behavior, unnecessary delay in seeking treatment, or when they complicate care.

### Psychological Testing

The psychosocial evaluation may include psychological testing. An extremely useful test is the Minnesota Multiphasic Personality Inventory (MMPI) which has been in use for many years

and is in regular use at Mayo Clinic. It is a low cost, self-administered and machine-scored test which is useful as a screening instrument. The results of this test return as a profile of scales which are not difficult to interpret and can easily be kept on the patient's chart. It is especially valuable for the clinician planning an unusual, complex procedure such as extensive surgery, radiotherapy, or chemotherapy. Psychological tests for organicity should be included in any workup when organic brain disease is suspected.

Every patient with extensive or chronic illness ought to have a social service evaluation. This would include the social worker's description of the patient's personality and relationships, understanding of family dynamics and of supportive networks. In the case of the upper or middle-class patient, there is often resistance on the part of clinicians to the use of social service. If it is presented as a routine part of the evaluation and if the social worker is introduced as a part of the treatment team, acceptance by patient and family will be high. In the indigent patient the need for social service evaluation and linkage with existing services is obvious.

The hospitalized cancer patient needs to be continuously assessed with regard to the nature of the current daily existence. This would include understanding the nature of rapport between patient and treatment team, the state of informed consent, the doctor-patient and nurse-patient relationships. If necessary, patient management conferences can be arranged which often help to correct problems and improve staff morale.

### Evaluation of Functionality

The patient may be objectively assessed with regard to functionality. The Eastern Cooperative Oncology Group uses a 5-point scale which is simple to score. A more complex estimate has been developed by Izak & Medalie.<sup>9</sup> They use a system of objective measurements which can potentially add up to a score of 100%. For example, in breast cancer the patient is rated for proper use of her prosthesis, for arm motion, for return to work, and other objective evidence of functioning; graphing these scores on a time axis

gives a rapid "gestalt" into the coping capacity of the patient. There is a need to develop a similar Quality of Survival Index which would be objective, simple, easy to score and which could find comprehensive use, making it easier to compare not only various modalities of treatment but to give a broader perspective on care.

We could see more readily "at a glance" by data analysis which programs were providing not only prolonged life, but time which is tolerable to patient and family, and with sufficient freedom from symptoms to permit meaningful activity. A comprehensive scoring system would include such factors as motivation, comfort, adaptation, coping and functionality relative to pathology.

Psychosocial evaluation, then, can be an ongoing and integrated part of the primary clinician's task of caring for the patient. At times, help from the social worker, psychologist, psychiatrist or medical sociologist can increase the physician's grasp of the situation and help him or her to be more effective in a highly stressful and challenging situation. ◀

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## Pediatric Perplexities

Ruth A. Seeler, M.D., Editor

# Aminophylline Toxicity

BY MEHERNOOR F. WATCHA, M.D., D.C.H., RESIDENT IN PEDIATRICS, AND  
JOHN H. KAHLER, M.D., CHIEF RESIDENT IN PEDIATRICS, COOK COUNTY HOSPITAL  
AND HEKTOEN INSTITUTE OF MEDICAL RESEARCH/CHICAGO

*"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. The editor welcomes suggestions for types of cases that the readers would like to have presented and discussed.*

*The current popular belief that there is a medication for every symptom has led some parents and physicians to a dangerous amount of over-medication and over-prescribing for infants and children. Whenever a physician is confronted by an acutely ill child, in addition to the usual diagnostic considerations, the differential diagnosis should include drug toxicity as a possible primary problem or the result of therapy for the original symptom complex.*

### Case Report #1

A 3-month-old Black male infant was transferred to Cook County Hospital with marked respiratory distress. Ten hours previously, he had been seen elsewhere because of fever, cough, and vomiting. He was treated with an injection of ampicillin and was given an aspirin suppository. The child had been previously in excellent health, showing good growth and development. Specifically, there was no history of heart murmur, feeding difficulty, or respiratory problems.

On examination he was a well-developed, well-nourished child in acute respiratory distress. There was marked restlessness and agitation, vacant staring gaze, and signs of dehydration, which included sunken eyes and anterior fontanelle, and marked diminished skin turgor. Rectal temperature was 105°F, heart rate by EKG 280/min., the respiration was 80/min. with deep sighing breathing. The pupils were equal and reacted to light and the fundoscopic examination was normal. Other than signs of an upper respiratory tract infection (cold), the physical examination was normal.

Initial laboratory data included a hemoglobin of 10.9 gm/dl, WBC 19,400 mm<sup>3</sup>, of which 79% were polymorphonuclear leukocytes, 18% lymphocytes, and 3% monocytes. Determination of the blood glucose, blood urea nitrogen, and calcium were normal, as were the electrolytes, with the exception of a low bicarbonate combining power. The chest X-ray demonstrated clear lung fields and a normal size heart. The EKG showed a supraventricular tachycardia at a rate of 280/min. The lumbar puncture revealed acellular

cerebrospinal fluid under normal tension and with normal chemical values. A catheterized specimen of urine had a specific gravity of 1.028, pH 5.0, large amounts of acetone, while being negative for protein, blood, bile, urobilinogen and reducing substances. A urine "Phenistix" done to detect salicylates was negative. The arterial blood gas tensions, with the patient breathing room air, revealed a pH of 7.52, pCO<sub>2</sub> 7.0 mms-Hg, and a pO<sub>2</sub> of 112 mms-Hg, giving the base deficit of 13.0 mEq/L. This was interpreted as a respiratory alkalosis secondary to hyperventilation. Blood was sent for toxicology analysis.

Immediate therapy was directed toward correction of the severe hypovolemia. During the first 8 hours he received 500 ml multiple electrolyte solution. At that time, the repeat arterial blood gas tension with the patient breathing room air showed that the pH was now 7.48, PCO<sub>2</sub> 12 mm-Hg, pO<sub>2</sub> 107 mm-Hg giving a base deficit of 13.0 mEq/L. The child developed carpo-pedal spasms which responded to intravenous calcium infusion. Over the ensuing 16 hours, an additional 500 cc of multi-electrolyte solution was infused intravenously. At the end of that time, the vital signs and arterial blood gas tensions were all within normal limits and the patient was acting normally.

The serum salicylate level was 0, while aminophylline level was reported at 21 mcgm/ml, which is in the toxic range. It would appear that an aminophylline suppository instead of aspirin suppository has been inadvertently administered to the child.

## Case Report #2

A 17-week-old Black male was thriving until 5 days prior to admission, when he developed a cough due to a "cold." He was seen elsewhere and antibiotics and antipyretics were prescribed. On the day of admission, the child began to have rapid labor respirations, vomited once, and was brought to the hospital. No further contributory history was obtainable.

Physical examination revealed an agitated infant with a harsh cough and severe respiratory distress. The respiratory rate was 64/min, heart rate 180/min, and the temperature 103°F. The child was well hydrated. Examination of the respiratory system revealed grunting, flaring of the alae nasae, bilateral intercostal retractions. Air entry was good throughout the lungs and there was no wheezing, ronchi or rales. Remainder of the physical examination was within normal limits.

The initial therapy was supportive with intravenous fluids, and a mist tent with oxygen. Three hours later the infant had a generalized seizure, which stopped spontaneously. A lumbar puncture revealed acellular fluid under normal pressure and the chemical values were subsequently normal. The arterial blood gas tensions revealed a pH of 7.14, pCO<sub>2</sub> 27.0 mms Hg., pO<sub>2</sub> 120 mms Hg. Determination of blood electrolytes, BUN, and glucose were normal. During this time it was noted that the child was having a profound diuresis, having a urine output of 110 ml in three hours. The intravenous fluids were appropriately increased. Six hours after admission, the child had a cardiorespiratory arrest and could not be resuscitated.

Subsequent history available after the child's demise was that in the 8 hours prior to admission, he had been given two aminophylline suppositories which contained 250 mg each, a dose of 65 mg per kg.

## Discussion

Theophylline and its ethylene diamine derivative, aminophylline, belongs to the xanthine group of drugs and have identical toxicities. In 1950, Gardner et al., reported a fatality in a 2 year old child approximately 13 hours after the ingestion of one tablet of theophylline combined with an antihistamine and phenobarbital (Tedral®).<sup>4</sup> Since then many additional deaths have been reported in infants and young children.<sup>3,6,8,10,12</sup> The recommended pediatric dose of aminophylline is 4-6 mg/kg of body weight

every 6 hours. Tablets contain 100 or 200 mg while the suppositories that are available contain 125, 250, or 500 mg. Thus, if an average 1 year old child weighing 10 kg was given even the smallest suppository, the dosage would be 12 mg/kg, far in excess of the safe dose. The distribution of aminophylline within the suppository is uneven, and hence the practice of dividing a suppository should be condemned as the concentration of aminophylline in the division is uneven and unknown. Lastly, the absorption of aminophylline from the rectum is erratic and unreliable.<sup>5</sup> Most cases of toxicity and fatality have been associated with this route of administration and rectal suppository should not be used in pediatric practice.<sup>3,6,7,8,10,12</sup>

The clinical manifestations of aminophylline overdosage are: (1) CNS stimulation, (2) increased gastric secretion, (3) diuresis, (4) dehydration, and (5) cardiac arrhythmias, hypotension and cardiovascular shock.<sup>5,11</sup>

CNS stimulation with restlessness and irritability is an early sign and may progress to tremors, convulsions and coma. Bacall et al. noted irritability in 6 out of 10 cases, with seizures in one.<sup>3</sup> Stimulation of the medullary respiratory center causes hyperventilation, resulting in respiratory alkalosis, a decreased ionic calcium and tetany, which responds to intravenous calcium salts. The increased metabolic rate and dehydration produces a metabolic acidosis.

Increased gastric secretion is manifested by nausea and vomiting at times severe enough to cause hematemesis, esophagitis and perforation.<sup>7,8</sup> Bacall et al. noted hematemesis in 7 out of 10 cases.<sup>3</sup> Nolke reported 4 deaths in a series of 13 cases; all 4 had ulcerative esophagitis and 2 esophageal perforations.<sup>8</sup>

Dehydration is secondary to the cumulative pathological losses from the gastrointestinal tract secondary to vomiting, from the respiratory tract due to hyperventilation and from the diuretic effect of aminophylline.

Cardiac arrhythmias, hypotension, cardiovascular shock and sudden death have been noted in aminophylline overdosage. The drug has a direct action on cardiac-pacemaker tissue, and a synergistic effect with epinephrine on cardiac inotropy and chronotropy, by increasing the intracellular cyclic 3' 5' AMP.<sup>9</sup> In addition, aminophylline releases catecholamines from the adrenal medulla.<sup>2</sup> Beta-adrenergic blocking agents such as propranolol have been recommended for use in aminophylline toxicity.<sup>1</sup> Continuous monitoring of the electrical activity of

*(Continued on page 157)*



# Adenovirus Type II and Cyclophosphamide Hemorrhagic Cystitis

By JOYCE E. ROYAL, M.D., TERRY O. HOPE, M.D., AND  
RUTH ANDREA SEELER, M.D./CHICAGO

*Current therapy of acute childhood leukemia requires the administration of multiple immunosuppressive and cytotoxic agents, each with an anticipated and identifiable toxicity. This paper represents two children with acute lymphocytic leukemia (ALL) who developed gross hematuria while on chemotherapy that included cyclophosphamide (Cytosan®). Hematuria due to cyclophosphamide induced hemorrhagic cystitis (CIHC) with bladder fibrosis is a well recognized risk of such therapy, however, it is important to investigate these patients fully for the usual causes of childhood hematuria.<sup>1</sup>*

## Case Reports

Patient #1, an 8 years old black male, was diagnosed as ALL in January, 1974. Complete remission was induced following 6 doses of vincristine (1.5 mg/m<sup>2</sup>/week) and prednisone (40 mg/m<sup>2</sup>/day P.O.). Following remission, he received prophylactic central nervous system irradiation. Maintenance chemotherapy consisted of cyclophosphamide (200 mg/m<sup>2</sup>/week), methotrexate (20 mg/m<sup>2</sup>/week) and 6 mercaptopurine (50 mg/m<sup>2</sup>/day) was begun. After 9 weeks of maintenance chemotherapy, he developed gross hematuria accompanied by frequency and dysuria. At that time, he had received a cumulative dose of 4.25 mg of cyclophosphamide (S.A.= 1 m<sup>2</sup>).

All drugs were discontinued. An intravenous pyelogram and voiding cystourethrogram were normal. Urine cultures were sterile for bacterial pathogens, but positive for adenovirus identified as type II by neutralization studies. Over the ensuing 6 weeks the adenovirus titer by complement fixation went from negative to 1:64. The platelet count was normal and other studies ruled out post streptococcal glomerulonephritis. A diagnosis of hemorrhagic cystitis due to adenovirus infection was made and he was restarted on maintenance chemotherapy. Subsequently, the child

had a leukemic relapse and has received intensive induction therapy, which included cyclophosphamide without recurrence of the hematuria.

## Comment

This patient was particularly instructed in that adenovirus type II was isolated from the urine on several occasions and subsequently, he demonstrated a rise in antibody titer to adenovirus. Adenovirus type II infection is relatively common cause of hemorrhagic cystitis in children.<sup>2,3</sup> Our patient continued to shed virus for a period of 12 weeks, which may be related to the immunosuppressive state induced by the cancer chemotherapy agents.

## Case Two

A 21 months old black male was diagnosed as ALL and induced into remission with 6 weekly doses of vincristine (1.5/m<sup>2</sup>/week), and prednisone (40 mg/m<sup>2</sup>/day) by mouth. Following documented bone marrow remission, he received central nervous system irradiation and was started on maintenance chemotherapy, including cyclophosphamide (200 mg/m<sup>2</sup>/week), methotrexate (20 mg/m<sup>2</sup>/week) and 6 mercaptopurine (50 mg/m<sup>2</sup>/day). The doses were periodically adjusted, depending on the absolute granulocyte count. After one year of maintenance therapy, his mother noted crying, enuresis, and frequency which was followed by day time wetting and finally hematuria. His total 12 month cumulative dose of cyclophosphamide was 2.6 gms (4.33 gms/m<sup>2</sup>).

Work up revealed a normal white count and platelet count. Urine cultures were sterile for

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JOYCE E. ROYAL, M.D., is a Resident in Pediatric Hematology-Oncology at Cook County Hospital, Chicago.

TERRY O. HOPE, M.D., is a Resident in Pediatric Hematology-Oncology at Cook County Hospital, Chicago.

RUTH ANDREA SEELER, M.D., is Chairman of the Division of Pediatric Hematology-Oncology at Cook County Hospital and Hektoen Institute for Medical Research, Chicago.



Figure 2. Intravenous pyelogram showing return of a bladder to normal size for a 3 year old child.



Figure 1. Intravenous pyelogram showing markedly contracted bladder.

bacteria and viruses. No serological changes to adenovirus occurred.

The intravenous pyelogram (Fig. 1) showed a small contracted bladder. Maintenance chemotherapy was resumed using 6 mercaptopurine and methotrexate. The hematuria and urinary symptoms gradually subsided over a 6-8 weeks period. A repeat intravenous pyelogram revealed a normal size bladder for a 3½ years old child (Fig. 2).

Nine months later, he had testicular relapse and was given reinduction therapy including vincristine, prednisone, and local irradiation. Subsequently, he has had a bone marrow relapse and second remission and was treated intensively with cyclophosphamide without recurrence of the hematuria. However, large volumes of fluid, in order to maintain a dilute urine, have been given along with the cyclophosphamide.

### Discussion

These two children, treated according to the same ALL protocol, developed gross hematuria 9 and 52 weeks after maintenance chemotherapy was started. Both children had been receiving cyclophosphamide on an intermittent single weekly dosage basis. CIHC has been found in some 2 to 40% of patients treated with cyclophosphamide for various conditions. Lawrence, et al.,<sup>4</sup> Fernbach, et al.,<sup>5</sup> and Pinkel<sup>6</sup> had incidences of CIHC of 8% (25/314), 9.1% (4/44), and 15.1% (5/33) respectively. Hemorrhagic cystitis as a complication of cyclophosphamide therapy has been recognized since its introduction<sup>1</sup>; however, more recently, the severity to which it can develop has become evident.<sup>7</sup> The frequency of severe CIHC is 1.6% (5/314) is much lower than the overall incidence, but represents a significant proportion (20%) of those who develop CIHC.<sup>4</sup>

CIHC is felt to result from prolonged contact of a high concentration of metabolic products of cyclophosphamide with the bladder mucosa.<sup>8</sup> The histological findings have included fibrosis of the submucosa blood vessels and severe ectasia which may then result in hematuria.<sup>1</sup> Cytological and cystoscopic studies do not always correlate well with the degree of hematuria and the symptoms in the patients with CIHC.

There is a higher incidence in Blacks than in Caucasians treated at the same institution with the same protocol.<sup>4</sup> A seasonal variation with a higher incidence during the summer months, possibly correlating with hydration, has been record-



ed. There has been a lack of correlation with the total dose of cyclophosphamide or the duration of therapy. The total dose has ranged from 2.0 to 45.3 gm/m<sup>2</sup> with a median of 10.1 gm/m<sup>2</sup> and the duration of therapy from 9 to 231 weeks with a median of 68 weeks.<sup>4</sup> With attention to maintaining hydration, cyclophosphamide has subsequently been administered to a number of these children without recurrence of the hematuria.

The method of administration by mouth versus intravenous has been investigated as to the relative frequency of developing CIHC. Theoretically, intermittent weekly doses should have a lower tendency to produce CIHC than daily regimens. With intravenous administration, the dose tends to be high, but the duration very short. This is then followed by a period of 7-14 days of rest before the next high dose of intravenous cyclophosphamide is given. The greatest amount of contact with the bladder mucosa occurs following daily oral administration of cyclophosphamide. This may account for the higher incidence of CIHC in patients receiving oral medication.

To minimize the bladder toxicity, cyclophosphamide should be given only in the morning, followed by large volumes of fluid so that the urine specific gravity remains below 1.010.

One's natural inclination would be not to use cyclophosphamide again in any patient who had developed CIHC. However, recent reports suggest that cyclophosphamide may be reinstituted after complete return of the urinary system to normal.<sup>4</sup> This has not been uniformly associated with a recurrence of hematuria provided detailed attention is paid to maintaining hydration and by the administration of the drug as a single daily dose early in the morning.

Cyclophosphamide is increasingly being used to treat non-neoplastic diseases including glomerulonephritis, idiopathic nephrotic syndrome, collagen vascular diseases, myasthenia gravis, multiple sclerosis, and ITP. It is increasingly important that when the anti-cancer agents are used in these non-neoplastic diseases, that careful appraisal be given to the risk benefit ratio. It is not unexpected that severe toxicity will be

seen with the increasing longevity and use of these agents in non-neoplastic conditions.

Currently, cyclophosphamide should be used with extreme caution in any non-life threatening illness. Its other toxicities, besides bone marrow suppression, include permanent and temporary sterility.

### Summary

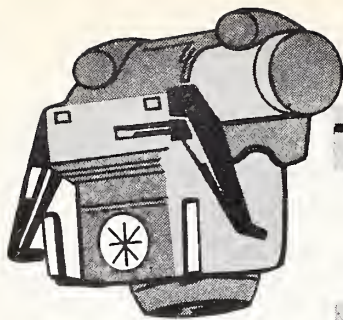
Two cases of hemorrhagic cystitis in children receiving cyclophosphamide for ALL are presented. One child illustrates the need for complete evaluation of the usual causes of hemorrhagic cystitis as his was due to an adenovirus type II infection. The other child had complete reversibility of a cyclophosphamide induced hemorrhagic cystitis. Hemorrhagic cystitis due to cyclophosphamide therapy can be minimized by giving large volumes of fluid accompanying the drug. The problem of CIHC is reviewed. ◀

### Acknowledgment

The authors are indebted to Robert Muldoon, Ph.D., Director, Department of Virology, Cook County Hospital, for virus identification and serological studies. Mr. A. Levin, Biological Photographer, Department of Pathology, Hektoen Institute for Medical Research, prepared the photography.

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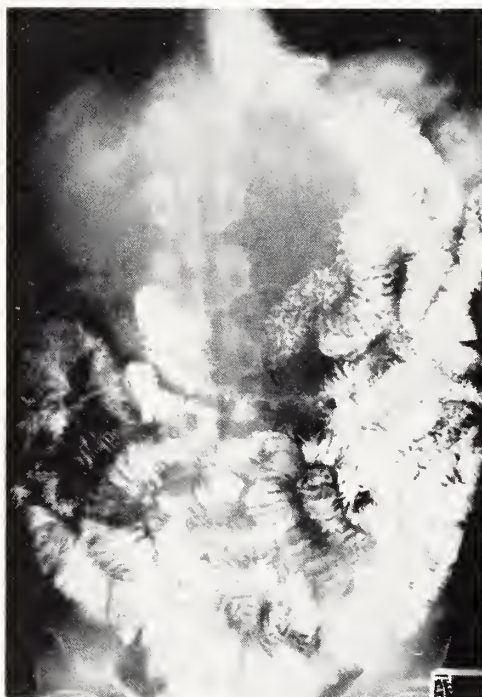
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## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

The patient is a 38 year old male who had a total gastrectomy for Zollinger-Ellison syndrome six years prior to this examination. For the past year he had had increasing difficulty in swallowing, with pain in the low chest following a meal.



**Figure 1.**

**What's your diagnosis?**

1. Metastasis to the esophagus
2. Carcinoma of the distal esophagus
3. Alkali esophagitis
4. Peptic esophagitis

*(Answers on page 142)*

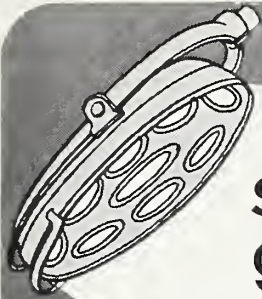


**Figure 2.**

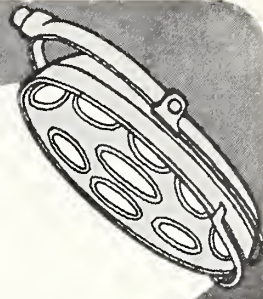


**Figure 3.**





# surgical grand rounds



Edited By JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 2, 1975.*

## Hemangioma of the Liver

**Dr. Stanley Carson:** A 33-year-old black woman was admitted to a hospital elsewhere one year ago with epigastric pain and pain in the upper part of her back of six weeks' duration. Although variable in intensity, the pain was constantly present. She also had low grade fever for which she took aspirin at night, and also complained of loss of appetite. The investigation at that particular hospital was quite thorough; however, the findings were not diagnostic. She had a normocytic, normochromic anemia and on one film, a radiologist commented that the left lobe of the liver was enlarged.

During the intervening months, the patient did not feel well and noticed an increase in her abdominal girth above her umbilicus. Her pain increased in intensity and on occasion caused her to "double over." She was unable to tolerate a normal size meal, becoming satiated after approximately three or four bites. Her febrile episodes continued and she grew more and more lethargic. She was admitted to the Passavant Pavilion on July 17, 1975. The remarkable physical finding was a large epigastric mass, approximately 10 cm in diameter. The mass was slightly tender and moved with respiration.

Laboratory studies demonstrated normocytic, normochromic anemia. Liver function tests, urinalysis, and coagulation profile were normal. A number of X-ray studies were obtained.

### Studies Made

**Dr. Harvey Nieman:** A study was made of the upper gastrointestinal tract. The conven-

tional barium study demonstrated a large impression on the lesser curvature of the stomach, compatible with a mid-epigastric mass. (Figure 1) Air was instilled in the stomach and a double density was apparent in this area.



Figure 1. Roentgenograms of the stomach demonstrated a pressure defect along the greater curvature of the stomach.

The lateral views demonstrated that the entire stomach was displaced posteriorly, by an anteriorly located mass lesion, consistent with the left lobe of the liver.

An ultrasound examination was performed and an echogenic mass was found. Normally, by this technique, the liver should appear relatively sonolucent or non-echogenic on cross section. In this patient, however, there were many internal echoes.

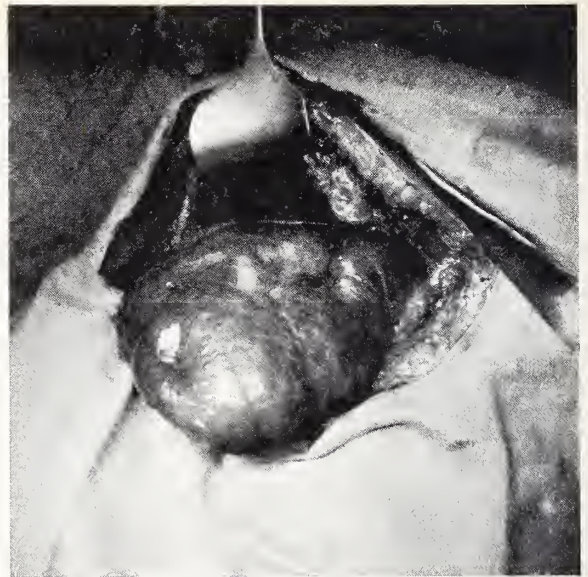
Angiography was then performed and several studies were carried out. First was celiac artery injection. With the tip of the catheter in the celiac artery, contrast material was injected. A persistent, nonhomogenous stain was seen arising from the anterior inferior area branch to the liver, which was somewhat signet ring shaped. (Figure 2) In addition, there were several other areas which had the same appearance. When the superior mesenteric artery was injected, one could see another area arising from collaterals from the pancreatic arcade.

A selective left gastric artery injection revealed that the left hepatic artery arose from the left gastric artery in this patient. Multiple areas of persistent staining, which were not homogeneous were seen extending into the splenic hilum. Throughout the mid epigastrium, persistent stains appeared to arise from the left lobe of the liver, from the anterior and posterior inferior arteries of the liver.

This radiologic appearance is quite characteristic of a giant cavernous hemangioma arising



**Figure 2.** Selective angiogram showed that the main supply for the tumor was the left hepatic artery, which arose from the left gastric artery.



**Figure 3.** The tumor was a large cavernous hemangioma which occupied the left lobe of the liver.

from the liver. The possibility of hemangiosarcoma was considered but from an angiographic standpoint, we could not detect evidence of malignancy in this patient.

### Procedure

**Dr. Stanley Carson:** Because of her weight loss and the possibility of a liver resection, she received oral alimentation, using an elemental diet. She tolerated this well and began to gain weight. Her hospital course was marked by continued spiking fevers to 103°, although blood cultures were negative.

After a standard bowel preparation, the patient was taken to the operating room and laparotomy was performed through an extended right subcostal incision. A large hemangioma of the left lobe of the liver was found with another, smaller hemangioma on the interior surface of the liver, between the left and right lobes, which were included in the resection.

The triangular ligament was divided and the left lobe was rotated into the operative field. Almost the entire left lobe was replaced by hemangioma (Figure 3).

The operative procedure was made easier by knowledge gained through angiography that the left hepatic artery originated from the left gastric artery. After ligation of this artery, a plane of dissection was established, and blood loss diminished.

Her recovery was satisfactory. Her therapy included hyperalimentation and antibiotics. She tolerated oral feedings by the fifth postoperative day and was discharged two weeks after operation.



## Specimen Pathology

**Dr. Hector Battifora:** The specimen consisted of a resected lobe of liver whose substance was largely replaced by a tumor mass. The specimen measured 16 x 18 x 6 centimeters and was wedge-shaped. The tumor mass, which was apparent beneath the smooth, fibrous capsule, was dark reddish purple and was well demarcated from the surrounding rim of liver tissue. On section, the mass was hemorrhagic and exuded blood freely from the cut surface. The mass contained several firm fibrous septae and cystic areas filled with myxoid tissue. Microscopic examination demonstrated typical vascular spaces containing red blood cells characteristic of cavernous hemangioma of the liver. Submitted with the tumor mass was an unremarkable gallbladder.

## Discussion

**Dr. Stanley Carson:** Hemangioma is the most common benign tumor of the liver. This patient's history is fairly typical of giant hemangiomas, which are generally defined as being more than four cm. in diameter. Most hemangiomas are asymptomatic and produce pain because of size and weight of the tumor or as a result of pressure on adjacent organs. It is estimated that only approximately 20% of hepatic hemangiomas are treated surgically. Hemangiomas may occur at any age, and have been reported from four months to over 70 years. They are cavernous, generally have a solitary capsule; and about half of them are solitary, confined to one lobe of the liver.

The most common finding is an upper abdominal mass, which enlarges slowly over a period of several months or years. The patient may experience upper abdominal pain or discomfort and fullness after meals, as was present in this patient. Fever is a common finding. In approximately 10%, the first clinical manifestation of the hemangioma may be the development of shock. Laboratory tests are usually normal, although there have been isolated cases of elevation of liver enzymes and bilirubin that returned to normal after resections. Now, the diagnosis can be made on the basis of angiography in most patients. Gastrointestinal X-rays and scans of the abdomen can determine the site of the mass or lesion, but are not as diagnostic as angiography.

When a hemangioma of the liver is found, surgical treatment is recommended to prevent spontaneous rupture, which is associated with a mortality of approximately 75%. Some degree of focal hemorrhage is usually present and explains the anemia found in most of these patients. There are some cases of hemangiomas

that have bled following biliary tract procedures, when they have perhaps been probed, but this is rare. Cardiac failure is also attributed to giant hemangiomas of the liver, a syndrome that occurs largely in children.

The preferred treatment is resection. Because approximately 50% are solitary and confined to one lobe, resection should be feasible in half of the cases, which is reflected in recorded cases of the past 30-40 years. In cases where one cannot resect, radiation alone or radiation with surgery has been used. Radiation provides symptomatic relief in many patients, but the long term follow-up for irradiation of giant hemangiomas is not good and recurrence of symptoms or spontaneous hemorrhage is frequent. Steroids and hepatic artery ligation have been largely used for patients who present with a syndrome of cardiac failure; in which case, it is necessary to refer them for further surgery or for radiation or to stabilize their total condition by doing something other than hepatic resection. The steroids are currently the favored mode in this regard, but hepatic artery ligation has been used in the past in a few cases with good success.

**Dr. Miguel Oviedo:** The only thing I would add to Dr. Carson's remarks is to emphasize that the treatment consists of surgical resection. When the hemangioma involves both lobes of the liver and you cannot resect the lesion, the patient may be treated with palliative radiotherapy, steroids, and hepatic artery ligation. The main reason for surgical intervention is to prevent rupture, because patients with a ruptured hemangioma almost always die.

Christopherson reported benign liver tumors in women on contraceptive steroids. Most of the cases have been diagnosed as benign hepatomas (liver cell adenomas). This series also includes patients with focal nodular hyperplasia of the liver. There were also examples of hepatic cellular carcinoma and liver cell hamartoma.

Our patient today had not been taking oral contraceptives, therefore, this is not the same type of tumor reported recently in the literature. Physicians should be alerted about the association between "the pill" and liver tumors, because many of the patients present with an acute abdomen with a very high operative mortality. ◀

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# A Time to Countersue

BY LEONARD BERLIN, M.D./SKOKIE

The system of government and law in our country is based on precepts of checks and balances. Every citizen in our society, whether acting as an individual or as a member of a group, must answer for personal actions—one must be accountable. Each of us—doctors, accountants, professors, blue collar workers, working people of all types—must abide by certain standards imposed upon us by our society. This includes lawyers.

Lawyers seem to have had it their own way in malpractice litigation for many years. They have made the rules, have determined guidelines of practice, and have escaped many checks or balances. Until now, that is. In malpractice cases, they have arbitrarily and unilaterally determined that a physician can be sued with very little if any cause, with immunity, and seemingly without penalty if it is found that there was no justifiable reason. Many lawyers have determined to allow a client to sue a physician alleging malpractice, even if that physician had little if anything to do with the claimed act of malpractice, because either the physician could then be forced to supply valuable testimony or because an insurance carrier would supply additional funds from which the suing attorney could draw. Lawyers have decided whom will be sued and for what reasons. And they have had to answer to no one for these decisions.

There was a time for that type of practice. But that time has passed. Today those practices can be interpreted as abuses—abuses that we can no longer tolerate. Today, the costs of medical

care have increased to such an extent that it has created a crisis. People are beginning to realize that much of this cost is directly due to the malpractice insurance premiums. They are beginning to learn that premiums are so high because there are too many frivolous malpractice suits filed and because even when a legitimate suit is filed, there are too many doctors named frivolously as co-defendants. People also are beginning to find out that when a doctor is simply named as a co-defendant in a suit, it costs his insurance carrier an average of \$2,500 in legal costs to just “open the file” in the case. They are beginning to understand that if an insurance company decides to defend a doctor in a suit, it can cost anywhere between \$5,000

and \$15,000, and up. People are beginning to realize that this is an intolerable situation that can be permitted no longer. It is time to make a change in the system.

There have been attempts to develop remedial legislation; but to date there has been no significant relief achieved in any state. Committees consisting of representatives from the legal community, the medical community and the insurance community, have met and have attempted to find solutions to the malpractice problem. None has

been found. Perhaps there is insufficient motivation on the parts of the attorneys and the insurance companies to change the status quo; perhaps the doctors have not been aggressive enough to change the status quo. I believe we doctors have a means to turn the malpractice situation around—to end the malpractice crisis—and to put malpractice back into its proper inconspicuous perspective. That means is countersuit.

Traditional and customary grounds for countersuit—malicious prosecution, abuse of process,

***“To every thing there is a season, and a time to every purpose. . . :***

***A time to be born, and a time to die;***

***A time to plant, and a time to pluck up that which is planted;***

***A time to kill, and a time to heal;***

***A time to break down, and a time to build up;***

***A time to weep, and a time to laugh;***

***A time to mourn, and a time to dance; . . .***

***A time to seek, and a time to lose; . . .***

***A time to keep silence, and a time to speak;***

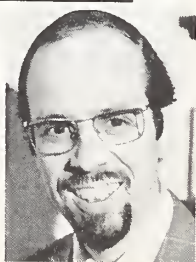
***A time to love, and a time to hate;***

***A time for war, and a time for peace.”***

***Ecclesiastes, 3:2-8***

***. . . And may I add, “A time to be sued, and a time to countersue!”***

LEONARD BERLIN, M.D., is attending Radiologist, Skokie Valley Community Hospital, Skokie, Illinois, and Clinical Assistant Professor of Radiology, University of Illinois Abraham Lincoln School of Medicine, Chicago.





defamation of character—have not been effective and have simply not been used successfully. A new and novel approach, a new cause of action, had to be developed. I believe this novel and innovative cause of action has been found, and it was used successfully in my recent, precedent-setting Cook County Berlin *vs.* Nathan *et al* case.

### The Suit

With the help of several imaginative and interested attorneys, I decided to accuse the plaintiff and her attorney of a “tort” for suing me frivolously and without reasonable cause. “Tort” is a legal term, defined as a violation by one person of a duty or obligation he owes another that thereby harms the latter. The complaint said essentially that the plaintiff in the original malpractice suit, along with her attorney, owed me a duty so as not to involve me in litigation without reasonable cause, that they both violated that duty, and that by so doing they harmed me. It further stated that not only did they violate that duty, but they did so “willfully and wantonly”—*i.e.* recklessly, deliberately, and unreasonably.

The attorneys only were accused in a second cause of action, a second “tort”: I said they owed me a duty of conducting themselves according to acceptable standards as devised by the legal profession, and that by instituting a lawsuit against me without proper prior investigation, they fell below those standards and thus were guilty of negligence. In essence, I accused the attorneys of the same charge as that brought against physicians—failing to meet the standards of their peers.

In order to prove legal negligence, standards against which to compare the defendant attorney's actions had to be determined. The American Bar Association has developed and published a “Code of Professional Responsibility.” All local, state and county bar associations have adopted it or a modification of it. This code, consisting of “canons,” “ethical considerations,” and “disciplinary rules,” has been enforced by the courts, and has been found to be a mandatory standard of conduct which every attorney, everywhere, must follow. The code includes many regulations, but the ones appropriate for my use were:

“A lawyer shall not handle a legal matter without preparation adequate in the circumstances” (*DR 6-101 [A] 2*);

“A lawyer is not justified in asserting a position in litigation that is frivolous” (*EC 7-4*);

“A lawyer has a duty and an obligation to treat with consideration all persons involved in the legal process and to avoid the infliction of needless harm” (*EC 7-10*);

“A lawyer shall not file a suit when he knows or it is obvious that such action would serve merely to harass or maliciously injure another” (*DR 7-102 [A] 1*).

I charged the lawyers with violating these standards, but I had to produce legal expert witnesses to testify that, in my specific case, the defendant attorneys did indeed violate those standards, and by doing so, were negligent—that they were guilty of legal malpractice. I found two such expert witnesses, and they so testified. The jury agreed with that testimony.

I attempted to use a third cause of action: barratry, which is the “wicked and willful incitement of a lawsuit between two people in the state.” However, the judge in my case asserted that it was his opinion that a charge of barratry could not be filed in civil court, that if one decided to pursue that cause, it would have to proceed through the State's Attorneys office. I am challenging this opinion; it will be left to the appeals court to decide if barratry is a viable cause of action.

### Result

Although I was successful in achieving a significant judgement against the plaintiff and the attorneys who filed the suit, this will have to be upheld on appeal. An appeal to the state Appellate or Supreme Court is under way, and it could be one or two years before final adjudication is made. However, Chief Justice Burger, of the U.S. Supreme Court, is on public record as having said he feels there are too many frivolous lawsuits cluttering up our courts, and that attorneys have not been held strictly enough to their own standards and guidelines. In the current milieu of opinions such as this and recent liberal court decisions, I feel confident and optimistic that our innovative and imaginative causes of actions will be sustained. In my opinion, the higher courts will have no choice but to hold attorneys responsible for their actions, just as all the rest of society are responsible for their actions.

The time has come for doctors in every city, in every county, in every state, to stand up and fight when they feel they have been involved

in a frivolous lawsuit, or when they feel they have been frivolously named as a co-defendant in a malpractice lawsuit. From the response I have had from all over the nation, from attorneys and doctors, I know there are many attorneys who will represent doctors in countersuits. I know there are many fine attorneys throughout our nation who will appear in court and testify against other attorneys who have violated the code of the legal profession. No longer must a doctor fear obtaining good legal representation; no longer must a doctor be told there is "nothing he can do" if he is frivolously sued; no longer must a doctor simply sit back and take it!

I am convinced that the legal abuses discussed must end, and they will end, in the courts. I am convinced that the final solution to the malpractice problem is in the courts—where it all began. The day has come for the courts to put an end to the legal malpractices that have caused the astronomical rise in our malpractice insurance rates, which in turn has caused an astronomical rise in health care costs. In 1932, Justice Learned Hand said, "Courts must in the end say what is required: there are precautions so imperative that even their universal disregard will not excuse their omission." I believe the courts did just that in my case, and they will continue to do so.

Medical colleagues, I say: if in every judicial district in this nation, there arise not one, not two, but many countersuits, the courts will be inundated and attorneys, as a result, held accountable for their actions. They must, for the first time, be punished for abuses. Yes, this in itself will cause some unfortunate problems in our courts—they will be cluttered up with even more litigation, delays in trial dates will increase, and legal costs will even go higher, and already over-burdened courts and judges will be even more over-burdened.

Maybe some injured patients who do have a bonafide cause for malpractice will be discouraged for a time from bringing suit. However, in the end, the pendulum will rest where it belongs—in the center. The pendulum that has swung unfairly against the doctors in recent years will be pushed away, perhaps too far at first. I am convinced that in the end, perhaps one year, perhaps two years, countersuits will slowly fade away and we will find ourselves back in the proper situation: if there is a legitimate cause of action, a suit will be filed, the injured patient will be compensated, and the offending doctor will be punished in the proper manner. This is where we must wind up; perhaps we

must pass through an age of countersuits before we get there.

I must issue one important warning: one may countersue only if there is cause. Simply because a doctor is named in a malpractice suit, or simply because one may be found not guilty in a malpractice trial, or simply because one's insurance carrier may settle for a nominal sum, are not necessarily justifications for countersuit. Doctors who countersue, and attorneys who will represent them, must abide by the same basic standards: one cannot sue frivolously, and cannot clutter up the courts with nonsense suits, and must not harass others without reasonable cause. Neither the courts nor anybody with any conscience can deny a patient or his attorney who feel they have a reasonable case of medical malpractice, and who have performed a reasonable investigation to substantiate that case, from his day in court. The right to sue must be preserved for all—for both the injured patient and the injured doctor. Neither can be permitted to abuse the judicial process.

The time to be sued frivolously and without fighting back is passed, and will never return; the time to countersue is now! ◀

#### Acknowledgement

I would like to publicly acknowledge and thank the following members of my "legal team" for their roles in bringing my historic lawsuit to a successful conclusion and in bringing all of us to this "time to countersue:" Ronald A. Drumke and Eugene L. Shepp, who developed and nurtured this lawsuit; Wayne B. Giampietro and Fredric J. Grossman, who brilliantly prosecuted this lawsuit in the courtroom; and Charles J. O'Laughlin and William Bruce Hoff, Jr., who had the courage and conviction to speak out against substandard legal conduct at the trial. To each of these gentlemen is owed, in my opinion, the gratitude not only of myself, but also that of both the medical and the legal professions.

#### Viewbox

(Continued from page 136)

**DIAGNOSIS:** *Alkali esophagitis*—Figure 1 demonstrates the result of a total gastrectomy. It is noted that the jejunal loop of bowel at the level of the anastomosis has ascended above the diaphragm. Figure 2 and 3 demonstrate a long narrowing of the distal esophagus with some rigidity. The loops of small bowel in Figure 1 demonstrate mucosal thickening which are changes ascribed to a degree of malabsorption.

On the esophagoscopy there were multiple small ulcerations demonstrated in the distal esophagus with bile seen to reflux up from the anastomotic site. It would be impossible to have a peptic esophagitis after the removal of the entire acid bearing stomach and this represents an alkali esophagitis.



# MEN OF MEDICINE, 1776-1976

## *Sidelights of American Pharmacology\**

BY CARL A. DRAGSTEDT, M.D./CHICAGO

Before one gets any further into this dissertation, it is important that he be disabused as to the nature of its content. If the title of this chapter happened to be "Highlights of American Pharmacology," there would be little disagreement as to what it should attempt to cover. It should begin with John Leigh's "An Experimental Inquiry into the Properties of Opium and its Effects on Living Subjects," published in 1786, which may be regarded as the first piece of experimental pharmacology done in America. There would be mention of the discovery of ether anesthesia and of other anesthetics subsequently, of the discovery of many hormones such as epinephrine and insulin, of the isolation of many active principles from plants such as ephedrine, and so on. There would be brief biographical sketches of the pioneers in American Pharmacology such as Horatio Wood, John Jacob Abel, Reid Hunt, Torald Sollmann, A. N. Richards, Yandell Henderson, and many others.

Merely hinting, as I have, as to what a chapter on The Highlights of American Pharmacology should include, demonstrates that such a title would warrant a volume rather than a chapter. My assignment is much more modest. It is to preface a volume of serious work without being overly serious itself. It is to call attention to some of the minor attributes of pharmacology and pharmacologists. It is to reminisce, reflect, and, perchance, amuse, as one contemplates the evolution of this discipline in America.

### **A Snaggle-Toothed Old Man**

The first pharmacologist that I became acquainted with was S. A. Mathews. I heard about him before I entered medical school and it was an amusing story. He had been downtown to a

meeting of the Institute of Medicine of Chicago. He returned to the Midway via the elevated railroad, getting off at 55th Street to walk diagonally across Washington Park, as was then customary. Before continuing with the story, I should explain that Mathews had a number of eccentricities. Besides being quite absentminded, he talked out loud to himself and had a peculiar festinating gait. He leaned so far forward, that, to catch up with his center of gravity, he had to intersperse a number of trotting steps between periods of walking ones. He had been inspired by some of the discussion at the meeting, and, as he crossed the park, he was thinking of two dogs upon which he had been conducting some studies. "Yes sir," he said, "I think I'll kill those two and examine their livers for glycogen."

As it happened, there were two young girls directly ahead of him, who overheard him and turned around to see a snaggle-toothed old man trotting after them. Alarmed that they were the intended victims of some maniac, they raced across the park to the police station. There were then some embarrassing hours before Mathews' colleagues at the University could assure the girls and the officers as to this pharmacologist's identity and harmlessness.

There is an additional story about Mathews that needs to be told in order to illuminate the reference to him as a "snaggle-toothed old man." When the great influenza pandemic appeared during World War I, it soon became evident that one of the major complications of this disease was the development of a pleural empyema. There then arose a great controversy as to the relative merits of draining this pus by means of a rib resection, which would necessitate a collapse of the lung on that side, or of draining it by means of a closed system of suction which did not. Dean Lewis, a professor of surgery on the Rush Medical College faculty, proposed to study

\*Reprinted from ANNUAL REVIEW OF PHARMACOLOGY, Vol. 6, 1966.

this problem by some controlled experiments on dogs. He arranged to work with Mathews, and they secured a variety of organisms from the bacteriology laboratory with which to inoculate the chest cavities of a number of dogs. But none of the cultures induced a dependable empyema in their animals. Contemplating this problem one day, and, no doubt influenced by the fetid odor coming from Mathews' mouth (which had been innocent for many years of any acquaintance with dentist or toothbrush), Lewis suggested that Mathews should spit into the dogs' chest cavities. According to the story, this produced an empyema which no method of treatment could mitigate.

I tell this story about Mathews for a definite purpose. At the time of this story, almost none of the medical schools in America provided laboratories for experimental work on animals in the various clinical departments. It was necessary for a clinician to arrange a liaison with someone of the preclinical departments, usually physiology or pharmacology, in order to conduct some animal experiments. Consequently, in reviewing the bibliographies of many of our earlier pharmacologists, one will find many titles of a strictly clinical character.

### Early Pharmacology Textbooks

One of the important sidelights of American Pharmacology has to do with the textbooks on this subject. Until the recent rapid expansion in the number of pharmacologists working for industry, government, or research institute, the overwhelming majority of pharmacologists were teachers in medical schools, dental schools, pharmacy schools, and nursing schools. Correspondingly, the texts available for their use presented an important consideration. When I first became acquainted with pharmacology at the University of Chicago, the texts used there were those of A. R. Cushny and of Meyer & Gottlieb. While Cushny did serve for a short period at the University of Michigan, and it was Yandell Henderson's translation of the Meyer & Gottlieb text that was used, neither book could be called American. How different it is now. There are a dozen or more excellent American texts of which we can be justly proud, and a number of these are being used in other countries.

Since it is virtually the only one of its kind, I would like to mention Jackson's book on experimental pharmacology by name. Having been a teacher during the depression era, when the bud-

gets for equipment were conspicuous for their anemia, I found Jackson's book to be an invaluable guide to the mechanic, technician, and the do-it-yourself teacher.

### Pharmacology Earns Respect

An important sidelight of American Pharmacology deals with the United States Pharmacopeia, which is the oldest national pharmacopeia of the modern type in the world. Founded by physicians under the leadership of Dr. Lyman Spalding in 1820, it has been supported by the leaders of the medical and pharmaceutical professions ever since. When men from the various professions came to devote themselves to those aspects of drugs and their actions which earned them the designation of pharmacologists, they were frequently drafted for service in the preparation and revision of this important work. When the Food and Drug Act was passed in 1906, adopting the standards of the United States Pharmacopeia as standards to be enforced under the Act, the importance of this work was greatly enhanced. The impetus which this gave to the study of many important pharmacological problems such as biological assay, etc. cannot be overemphasized, since there was now the possibility that some of these pharmacological procedures might be challenged in the courts.

A somewhat similar sidelight on American Pharmacology is provided by the Council on Drugs of the American Medical Association, which began its career as the Council on Pharmacy and Chemistry. The Council, consisting of physicians, pharmacologists, and allied scientists, by its regular publication of *New and Nonofficial Remedies*, *Useful Drugs*, *New Drugs*, adverse drug reaction reports, and numerous related reports as to new drugs or new findings with respect to old drugs, has performed an extremely valuable service to the medical and allied professions. The Council was under the guidance of Torald Sollmann for so many years, that, despite its varied composition, American Pharmacology can claim a major share of the credit rightly coming to this agency.

Additional sidelights on American Pharmacology are provided by the establishment of Poison Control centers, the Commission on Drug Safety, the Pharmacology Study Section of the National Institutes of Health, and many other agencies which utilize the services of pharmacologists in a more or less specialized manner. But there seems no need to call the entire roll to



validate the claim that American Pharmacology, although a junior discipline in years, has worked hard to earn the respect of its colleagues.

### **Academic Pharmacologists vs. Industry's Pharmacologists**

An important sidelight on American Pharmacology is the story of the relationship between academic pharmacologists and those employed by industry. When the American Society for Pharmacology and Experimental Therapeutics was first founded (as a sort of stepchild of the American Physiological Society), those regularly employed by industry were specifically barred from membership. They were thus branded as unclean, as being scientists with ulterior motives and feet of clay, as having sold their integrity for a mess of pottage. They could belong to the American Physiological Society and thus attend the meetings of the Federation Societies. Consequently, there were occasions when some of the most important papers in pharmacology were presented before the other Federation Societies. This was an embarrassment. In the 1930's an effort was made to rewrite the Constitution, making provision for "Associate Members," but this was violently opposed by some of the more prominent members as permitting these outcasts to "get one foot in the door."

The policy of excluding employees of industry may have had some apparent justification at its inception, but it soon became clear to many that it was a shortsighted and selfdefeating policy. Although Gruber's efforts to revise the Constitution failed at the time, they paved the way for later efforts. There is reason to believe that A. N. Richards may have been most instrumental in the reversal of the Society's position. When he announced that he was serving as official consultant to Merck, and when he was instrumental in bringing Hans Molitor over from Meyer's laboratory to take charge of the Merck pharmacology department, he succeeded in overcoming the fears and scruples of most of the members. As there were already "commercial" men of such unquestioned ability and unimpeachable integrity as K. K. Chen to point to, the bylaws were soon amended to permit membership to all qualified pharmacologists. Thus, this chapter in American Pharmacology has a happy ending. For my part, I am pleased to record that I have had many pleasant and rewarding contacts with the pharmacologists employed by industry, and am grateful to those who gave me much valuable assistance while I was at Northwestern University.

### **Humorous Sidelights**

I now come to a different category of sidelights with respect to American Pharmacology. Nearly all of the pharmacologists I came to know, admire, and respect, had a wonderful sense of humor. It may well be a pejorative aspect to my task, but it would be shirking my responsibilities if I neglected this area of discussion.

For example, a sidelight of American Pharmacology consists of the witicisms and bon mots contributed by its members to the service of those who must lecture and teach on this subject. I now refer to unpublished items, and thus rely upon an unreliable memory for a record of these gems. I have forgotten completely all the "barbarisms" of Henry Barbour, and while the pungent profundities of Chauncey Leake which have been published are familiar, the unpublished ones have leaked away. Even "Moe" Seevers' graphic descriptions of his morphine-addicted monkeys grow dim. But I still recall how Paul Hanzlik concluded his presentation of the evidence for the prophylactic efficacy of bismuth against syphilis by stating that he had established a sound basis for that well-known aphorism "Bismuth before Pleasure"; and how Charles Edmunds concluded that gold could not be considered completely inert pharmacologically, because there was overwhelming evidence that it had a healing effect upon the itching palm.

I have forgotten who the pharmacologist was who stated that a lecture on the pharmacology of alcohol would be one sort of treatise if the opening statement read: "Alcohol is an ethyl hydroxylated hydrocarbon which boils at 78.5 degrees C and freezes at -117.3 degrees C," and quite another sort if the opening statement were: "Alcohol is the distilled essence of ripened grain, born of soil mated with sunshine, flavored with the secrets of the flowers, and softened by the hand of time." I am inclined to accuse David Macht because he wrote such a fine treatise dealing with the pharmacology of alcohol as depicted in the Hebrew Bible, but I recognize a certain Omar Khayyam flavor also. I have but vague memories of Ross McIntyre's lecture on curare in which he described Claude Bernard's journey through the Amazon jungle with a retinue of retainers dragging a depolarized polar bear and even more vague memories of many other scintillating discourses. It is my belief that some of these gems would be remembered more readily if they were phrased in a catchy rhyme or set to a catchy tune. That is why I wrote my rhyme on Histamine, and many friends have told me that they were grateful to Kipling's pattern of versi-

fication for its assistance to the memory process.

In addition to the witticisms which have flavored pharmacology so well, there are assorted histrionics which have illuminated the scene. I am told that Carl Pfeiffer's demonstrations of the explosive hazards of various anesthetics cannot be excelled. Theodore Koppanyi's demonstration of postural apnea in the duck is a masterpiece not to be forgotten. Harvey Haag's performance of nailing his cigar to the lecture desk before turning to write something on the blackboard so that his students would not seize it and pass it around for all to enjoy, is not in the same category of course, but it deserves mention because it was a regular performance whenever he lectured about nicotine and tobacco. The graphic picture of "Pete" Geiling wading in his boots into a whale's carcass in order to chop out the pituitary glands should never be forgotten.

### Homeopathy and Pharmacology

The death of homeopathy may be considered as a sidelight of American Pharmacology which does not reflect much credit upon professional pharmacologists. As may be recalled, homeopathy was a doctrinal discipline based upon two major doctrines. The first was *Similia Similibus Curantur* (like cures like) and will be considered no further. The second was to the effect that the therapeutic efficacy of a drug increased progressively as the dose was progressively decreased by dilution. In spite of the fact that the study of the dose-effect relationship of a drug is a major task for the pharmacologist, and that there was therefore a vast amount of well-controlled data with which to impugn this esoteric concept, there is little evidence that its death was materially hastened by the labors of the pharmacologist. There is, on the contrary, reason to believe that President Abraham Lincoln was more effective in this connection. The story goes that Lincoln, when considering an application from a homeopathic physician for a commission in the medical department of the army, and after having had homeopathy explained to him, said: "Well, I may not know much about medicine, but I know enough about farming to know that you cannot fertilize a farm with flatus. The application is denied."

There is another amusing example of an episode in American history bearing upon this pharmacological problem of dose-effect relationship. During the 1920's the United States undertook the great experiment of prohibition. This fos-

tered considerable interest in the study of the pharmacology of alcohol since, as A. J. Carlson phrased it, the government had made the physician the only legal bootlegger by authorizing him to prescribe it for medicinal purposes. The upshot of these studies was that doctors were prescribing whiskey to stimulate gastric secretion, to cure anorexia, to relieve chronic bronchitis, to act as a sedative to the nervous system, and a vasodilator to the circulatory system and so on. But, and this is the intriguing pharmacological question, it was always prescribed in 16-ounce quantities because this was what the law permitted.

### Unpublished Research

If it can be said that a highlight of American Pharmacology is a piece of research that has been conducted and published, perhaps it can be considered as a sidelight to mention some that have been conducted but not published. I am informed by one of my colleagues that an anatomist was greatly intrigued by the fact that, while there were occasional instances of dextrocardia and even situs inversus, the heart was almost always located on the left side. When he learned that epinephrine, which seemed to him to be the body's dominant hormone, was a levoratory compound, he immediately jumped to the conclusion that this was the explanation. He asked his pharmacology consultant for some potent dextrorotatory compound in order to test his theory. Dextroamphetamine was made available. Some weeks later, the anatomist reported to the pharmacologist that he had injected a pregnant bitch daily throughout her pregnancy with dextroamphetamine, but that the bitch had finally delivered seven puppies, none of which had dextrocardia. "Ah," the pharmacologist rejoined, "but you're left-handed, and this influence, although subtle, could well vitiate the result. You should repeat the experiment with a right-handed assistant and, furthermore, it would be well also to administer some monoamine oxidizing agent which inhibits levoratory compounds." To my knowledge, this more sophisticated experiment has not been conducted. There are wonderful things yet to be done!

### Conclusion

I close this *mélange* on a more somber note. About the same time that I received the invitation to write something as to the sidelights of American Pharmacology, I received another let-



ter. It was from a faculty committee assigned to make recommendations with respect to their pharmacology department. The department chairman was retiring and the question at issue was, should the names of some potential successors be presented, or should they recommend that the department of pharmacology be discontinued, its teaching and other functions being allocated to the junior staff men in physiology and biochemistry? Thus, at the same time that I was asked to consider the sidelights of American Pharmacology as a whole, I was also asked to contemplate the twilight of a pharmacology department at one of our major universities, which could well presage the twilight of American Pharmacology.

I shall not bother with my rather explosive rejoinder. The American Society for Pharmacology was formed as a sort of stepchild to the American Physiological Society and, to a considerable degree, American pharmacologists have been accorded the courtesies traditionally reserved for stepchildren. Since they use the same instruments and techniques common to the other biological scientists, there is no badge for the pharmacologist in the way that a microscope is a badge for a histologist. By the same token, a number of important contributions to pharmacology come from investigators who are not primarily pharmacologists. Consider, for example, du Vig-neaud's work on the relationships between the chemical functional groups and the biological activities of the pituitary hormones for which he received the Nobel Prize.

The ill-defined zone of what comprises pharmacology is thus partially responsible for this stepchild situation. I would add other reasons. The chemist who isolates or synthesizes a new compound, and the clinician who first observes that it does something apparently useful, are placed in the role of brave and successful explorers. They also become promoters with respect to it. Even though they may have no financial interest at stake, there is an *ipso facto* stake as to credit and glory. The pharmacologist, on the other hand, often appears in the role of critic and skeptical judge. His labors as to its mechanism of action, fate in the body, factor of safety, and so on, frequently put him in the position of a jealous rival seeking to demean and degrade the discovery.

There is another reason. It is only recently that we have established The John J. Abel Prize in Pharmacology and The Torald Sollmann Award in Pharmacology to recognize outstanding contributions in our area of study. There should be several more of these kinds of awards to help in this task of identification. It would not matter whether they took the form of walking canes, dinner plates, or loving cups, such as some of our sister societies favor, or amulets with some sort of cryptic significance to the healing arts. They would help to identify the type of "pharming" we are concerned with.

Thus I conclude with the hope that this portrayal of some of the sidelights of American Pharmacology, may help postpone the day when we are asked to contemplate its twilight. ◀

## An Account of a Scarlatina Epidemic, 1839

BY RONALD D. GREENWOOD, M.D.

*In the early years of this country, Streptococcal infection occurred in truly epidemic proportions. In the summer months of 1839, Scarlatina, as it was called, occurred in the southwestern part of Armstrong county and the southeastern part of Butler County in Pennsylvania. Dr. D. M. Borland, a practitioner in this area, recorded the details of this epidemic.<sup>1</sup> This exemplifies the danger of this infection in a time when there was no real treatment and provides a view of the therapy which was employed.*

### Scarlatina Appears

"Its first appearance was in the village of Freeport, where it presented an unusually malignant character. Of the malignant cases which were ushered in by vomiting and purging, two terminated fatally; one in twenty-two, and the

other in fourteen hours after the first manifestation of the disease. In these cases there was great restlessness and prostration of strength, coma commencing a few hours after the attack, from which the system never reacted; very small and frequent pulse; the extremities became cold; the eyes turned up under the lids; the countenance

sank; the lips became purple; the pupils dilated, and were very sensible to light; with every manifestation of cerebral congestion.

"One of these cases, which occurred in a child four months old, was protracted to the seventh day. There was extensive ulceration of the tonsils, extending to the posterior nares, giving rise to an acrid discharge, which excoriated the parts with which it came in contact. The reaction was imperfect; the eruption appeared imperfectly on the fourth day, but soon disappeared; collapse now supervened; the heat of the surface began to sink; the pulse became very frequent and feeble; the tongue dark brown; sordes on the teeth; the animal powers entirely prostrated; to which succeeded convulsive twitchings of the extremities, and death.

### Other Manifestations of the Disease

"The details of another fatal case will exhibit the different modifications of the disease, as it occurred in this epidemic.

A child, two-years-old, was attacked with the ordinary premonitory symptoms, followed by pain in the head, nausea and vomiting; pains in the loins and extremities, with general muscular prostration; an eruption, of a livid hue, made its appearance on the fourth day; the pulse, though in the commencement active, has now become small and feeble; delirium appeared with the eruption, and in a short time terminated in coma; the cheeks suffused with a livid flush; the eyes dull; dark-colored sloughs appeared on the tonsils; the nose discharged an acrid fluid; the extremities became cold, and death closed the scene.

"This epidemic commenced its ravages in the latter part of May, and continued until the first of December, under every variety, from the most mild to the most malignant form. No class or age appeared to be exempt from it; it attacked alike the child and the adult. I have prescribed for it in an infant of three weeks old; even persons who had formerly been the subjects of the disease suffered very much from sore throat.

### Treatment

"In the congestive cases, my object was to equalize the circulation, and to arrest the violent vomiting and purging; for this purpose, mustard was applied to the stomach and extremities, together with rubifacients, composed of tinct, capsic, and aqua ammonia. As soon as reaction was

established, I commenced with small doses of calomel, repeated every two hours until it operated on the bowels. Subsequently I gave cold-pressed castor oil, to keep up a regular but moderate evacuation of the bowels throughout the disease. As a gargle, I used pyroligneous acid and water, and chloride of soda and water, in the proportion of twelve parts of water to one of the other ingredients. With a view of lessening the swelling and soreness of the tonsils, I made use of equal parts of vinegar and turpentine, to be rubbed on until it produced an eruption, which it generally did in the course of a few hours, and with the happiest effect.

"After reaction was established, the skin became hot and dry, and the patient restless, I used, with the most gratifying results, cold vinegar and water, with which I ordered the patient to be sponged every half hour. This remedy appeared to act so promptly in soothing the patient that frequently a calm and refreshing sleep was induced ere the sponging operation was completed, out of which the little sufferer awoke with all the symptoms mitigated. To aid the refrigerant effects of sponging, the patient was lightly covered, and cool air freely admitted into the chamber.

"During convalescence, which was generally rapid, I enjoined a light, but nourishing diet, and to guard carefully against the influence of cold and variable weather. The former part of the above treatment is adopted only to those cases in which there was a want of reaction. Such is the plan of treatment which I found most available in the present epidemic. I reverted to emetics of ipecac, but they proved so unavailing that I subsequently abandoned them entirely. Indeed, sponging was the sheet-anchor of my hopes."

Streptococci were not seen until 1874 when Billroth and later Pasteur (1879) isolated micro-organisms from human materials. The pathogenicity of the organisms was demonstrated in animal experiments in 1881 by Ogston.<sup>2</sup> ◀

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### Acknowledgment

I am indebted to the Francis A. Countway Library of Medicine, Harvard Medical School, for use of historical materials.



# Doctor's News

**IPS TO HOLD 3rd ANNUAL FALL WEEKEND MEETING**—The Illinois Psychiatric Society will hold its 3rd Annual Fall Weekend Meeting, November 5-7, 1976, at the O'Hare Marriott, Chicago. According to Drs. Alex J. Spadoni, IPS President, and Anne M. Seiden, Program Chairperson, the three-day session will feature symposia, workshops, lectures and film presentations on a variety of socio-economic and clinical issues. For further information, please contact the Society's offices at 55 East Monroe, Suite 3510, Chicago, Illinois 60603 (312/263-7150).

**FIRST INTERNATIONAL GLAUCOMA CONGRESS**—The world's leading medical authorities on glaucoma will lecture on their latest research findings at this meeting to be held January 31-February 1, 1977, at the Diplomat Hotel, Hollywood, Florida. The glaucoma congress is being held in conjunction with the 12th Annual Scientific Assembly of the American Society of Contemporary Ophthalmology, and is sponsored by Lederle Laboratories. The program meets the criteria for 42 hours of credit in Category I for the Physician's Recognition Award of the AMA and for the ASCO Certificate of Advanced Studies in Ophthalmology. For further information contact: John Bellows, M.D., Director, ASCO, 6 N. Michigan Ave., Chicago 60602.

**MEDICAL DISCIPLINARY BOARD OFFICERS ELECTED**—At its July 7 meeting the newly formed Medical Disciplinary Board selected George Caleel, D.O., chairman; Helen C. Bonbrest, M.D., vice chairman; and Willard C. Scrivner, M.D., secretary. The Board will meet on the first and third Wednesdays of each month.

**MALPRACTICE RESEARCH, INC.**—Sound like an organization to study the roots of the malpractice problem? It's not. This company offers a service which allegedly consists of analyzing individual medical records for evidence of possible malpractice. Operating out of Herndon, Virginia, it has been mailing brochures to patients using Chicago area hospitals. A reliable source reported on a test case sent to Malpractice Research, Inc. for a routine hospitalization. The company responded by writing the patient's physician implying that for a fee, it would produce a favorable report, supporting the care given by the physician. If the physician chose to ignore this solicitation, the letter continued, a copy of the report could be obtained for a fee, which would be helpful in preparing for upcoming litigation in the case. When the physician in this case ignored the solicitation, his patient received a 20 minute tape recorded consultation which purported to justify a malpractice claim.

The Journal has learned that federal authorities are investigating the details of this case involving Malpractice Research, Inc., for possible violations of the law. Anyone who has information about Malpractice Research, Inc., including copies of letters and envelopes from this company, is asked to contact the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.

**PHYSICIANS IN THE NEWS**—**Paul E. Singer** is the new President of Illinois State Medical Insurance Services, Inc., the operating arm of the insurance company. He began in this capacity June 1. Previously Mr. Singer was with Continental Casualty Company. He graduated from the University of Chicago and is a member of the American Academy of Actuaries and an Associate of the Casualty Actuarial Society. Mr. Singer resides in Homewood with his wife and three children.

1976-77 AMA officers installed at the Annual Convention in Dallas are: **Richard E. Palmer, M.D.**, Alexandria, Va., president; **John H. Budd, M.D.**, Cleveland, Ohio, president-elect; **Francis T. Holland, M.D.**, Tallahassee, Fla., vice president; **Tom E. Nesbitt, M.D.**, Nashville, Tenn., speaker of the House of Delegates; **William Y. Rial, M.D.**, Swarthmore, Pa., vice speaker. Re-elected to the Board of Trustees were **Frank J. Jirka, M.D.**, Chicago, and **Lowell H. Steen, M.D.**, Hammond, Ind. Elected to the Board were **John J. Coury, M.D.**, Port Huron, Mich., and **Hubert A. Ritter, M.D.**, St. Louis. **Raymond T. Holden, M.D.**, Washington, D.C., was re-elected chairman of the Board of Trustees. **Jere W. Annis, M.D.**, Lakeland, Fla., was re-elected vice chairman of the Board.

The Allergy and Clinical Immunology Society of Illinois, Chicago Society of Allergy recently elected the following new officers for 1976-77: **Robert J. Becker, M.D.**, president; **Angelo E. Falleroni, M.D.**, president-elect; and **Jerome H. Lippert, M.D.**, secretary-treasurer. The Chicago Medical Society also announced its new officers: **Herschel Browns, M.D.**, president; **Morris T. Friedell, M.D.**, president-elect; **Charles W. Schlageter, M.D.**, secretary, and **Andrew Thomson, M.D.**, treasurer. **Lawrence L. Hirsch, M.D.**, was named chairman of the Council of the Chicago Medical Society and **C. Larkin Flanagan, M.D.**, vice chairman. Councilors-at-large are **A. Everett Joslyn, M.D.**, **William M. Lees, M.D.** and **Herman Wing, M.D.** Alternate councilors-at-large elected were **Gaylord Nordine, M.D.**, **Julie Etta Olentine, M.D.**, and **William Frederick, M.D.** Elected trustees were **Arthur Fischer, M.D.**, **Andrew Thomson, M.D.** and **B. Franklin Lounsbury, M.D.**

The Chicago Pediatric Society elected new officers to serve one year terms at its May 19, dinner meeting. They are: **Bennett R. Sherman, M.D.**, president; **Lowell M. Sollar, M.D.**, vice president; **Thomas P. Driscoll, M.D.**, secretary; **Rosita S. Pildes, M.D.**, treasurer; and **Robert Rosenfield, M.D.**, editor. Executive committee members are **Domingo Ocherony, M.D.** and **David Lee, M.D.** Also at this meeting several awards were presented: the Joseph P. Brenneeman Award to **Ralph Kunstadter, M.D.**; the Archibald F. Hoyne Award to **Paul H. Holinger, M.D.**; and the Distinguished Service Awards to **Emanuel Padnos, M.D.**; **Samuel Hoffman, M.D.**; **Harry M. Levy, M.D.**; **Raymond F. Grissom, M.D.**; **Vida B. Wentz, M.D.**; **Joseph N. Rappaport, M.D.**; and **W. L. Crawford, M.D.** **George Shropshear, M.D.** was elected treasurer of the Illinois Council on Continuing Medical Education on July 15. He fills the vacancy left by Dr. Robert Fox, who resigned from the ICCME Board because of his new duties as chairman of the ISMS Board.

Several other new appointments and elections recently include: **R. Ross Haeger, M.D.**, Oak Park, elected to the Board of Trustees of West Suburban Hospital; **Truman O. Anderson** appointed executive dean of the University of Illinois College of Medicine; and **Charles P. Perlis, M.D.**, named as the first occupant of the Samuel G. Taylor III, M.D., Chair of Oncology at Rush-Presbyterian-St. Luke's Medical Center.





## *On Consumerism*

The federal government has decided that consumers should constitute a majority on HSA boards.

I have no argument against the concept that the consumer (or customer or client or patient) has the right to the best choice of products, service or advice. He is entitled to a square shake. But does this right qualify him to control important decision making processes?

I, for example, am a consumer of electricity. Does that qualify me to sit on the board of the utility company? Is the ordinary motorist competent to manage the affairs of General Motors?

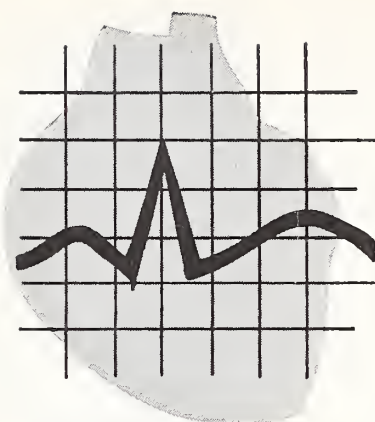
Complex problems must be solved, rather, by people with the training to deal with those problems and the conscience and professional standards to use their training for the good of all. Surely, we as responsible professionals can appreciate and respond appropriately to consumer needs and problems.

I fervently hope that government can come to recognize that public service of any sort requires the same kind of expertise that a corporation needs to operate at a profit. The best qualifications are more important in the former than in the latter because, at stake, is the welfare of human beings.

We as professionals must keep the public and the legislators aware that consumers' rights and consumers' abilities do not necessarily go hand in hand. In fact consumers' rights can only be affected adversely by inefficient and irrational decisions made by unqualified people.

*Joseph H. Skom, M.D.*

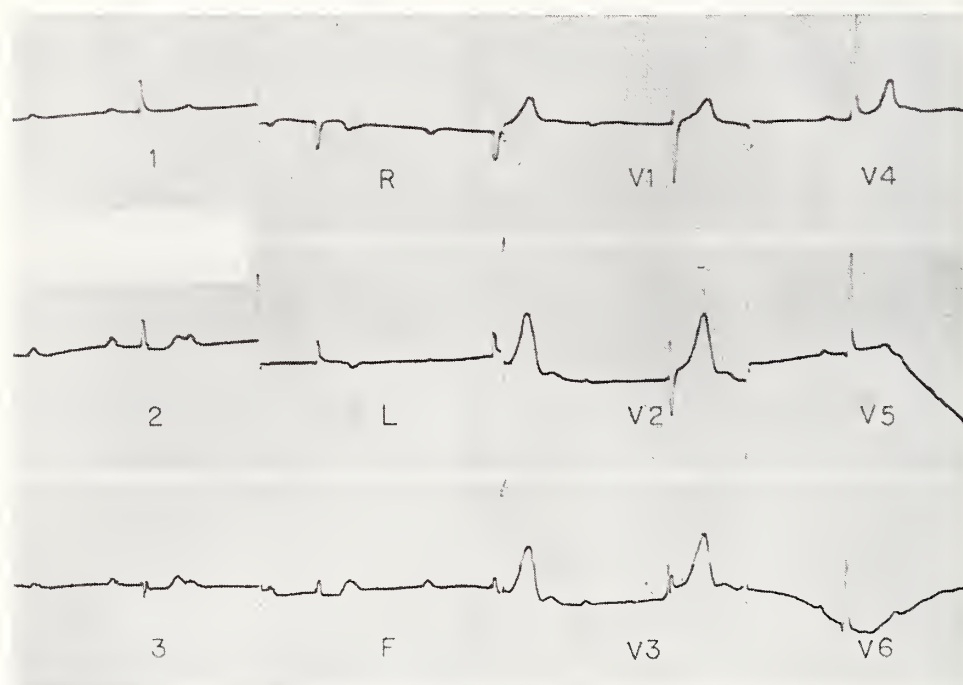
Joseph H. Skom, M.D.



## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RINGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

A 70 year old man presented for evaluation because of a slow pulse. Although retired, he worked regularly as a part-time chauffeur. He had noticed some light-headedness which seemed to be worsening as well as intermittent cloudy vision. His physical examination was normal except for a pulse rate of 35 beats per minute. A chest X-ray was normal. The 12 lead ECG (Fig. 1) and a 3 lead rhythm strip (Fig. 2) are shown.



**Figure 1.**



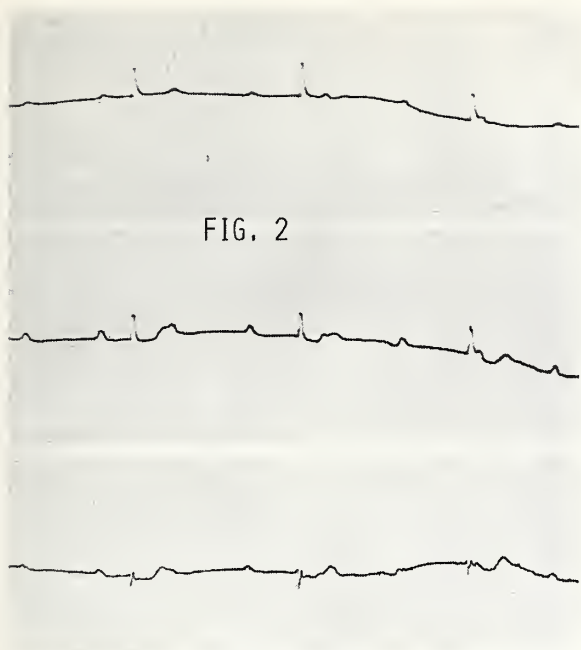


FIG. 2

Figure 2.

### Questions:

#### 1. The ECG shows:

- A. Complete AV dissociation.
- B. Acute inferior wall myocardial infarction.
- C. Bilateral bundle branch block.
- D. Sinus node arrest.
- E. Complete AV block.

#### 2. The treatment for this condition could include:

- A. Catecholamine pressors such as Levophed.
- B. Digitalis given rapidly intravenously.
- C. A demand pacemaker.
- D. Quinidine or procainamide.
- E. All of the above.

(Answers on page 157)

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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ABINGDON:** Urgent need for FP/GP's. West-Central industrial/farming section. Educational, cultural, recreational environment. Join only physician in modern, well-equipped medical building. No investment. Future assured. Ten minutes to two new JCAH hospitals-470 beds. Convenient to medical centers. Available housing. Contact Ruth Bradway, Box 145, Abingdon 61410. PH: (309) 462-2120. (10)

**CHICAGO:** Internist: board certified, wanted for association with hospital based medical/surgical group. Very large, active practice. North side Chicago. Unusual opportunity. Write Mr. C. M. Rappaport, Director of Personnel, 5700 North Ashland Avenue, 60660. (12)

**ARLINGTON HEIGHTS:** Board Certified Family Practitioner wishes associate who is Board certified or eligible in Family Practice. Modern office located across from Community hospital. Liberal salary and time off for study and vacations. Partnership after one year. Send resume to: Dr. Alan M. Hollett, 605 W. Central Rd., Arlington Heights 60005. (12)

**CHICAGO:** Comprehensive Health Care Center in the Metropolitan Chicago area has positions available for primary health care physicians. Center is located in close proximity to Community Hospital. Regularly scheduled hours. Financial arrangements will be discussed and will be commensurate with qualifications. Write or call: P. Pratscher, c/o Joliet Community Medical Center, 450 Prairie, Calumet City, IL 60409, Phone (312) 862-3100. (11)

**CHICAGO:** Physician needed for well established, ultra modern medical center. Full laboratory and X-ray. Congenial working conditions and excellent co-workers. Good hospital associations. No evenings or weekends. Clinic located south side, near lake. Contact, Mr. Lawrence, Booker Family Health Care Center, 747 E. 47th, Chicago, 60653. (312) 624-4800. (1)

**COLLINSVILLE-EDWARDSVILLE:** Progressive towns, 15 miles from Downtown St. Louis. Ample recreational facilities, S.I.U. Campus nearby. New Community Hospital will open this summer. Need a qualified Ophthalmologist. No initial investment needed. Excellent opportunity for the future. Contact Mrs. Hall, 657 E. Broadway, East St. Louis 62205, (618-345-0417). (12)

**FAIRFIELD:** Group of 4 physicians, GP, gen. surgeon, Gyn.-OB, and pediatrician, looking for another OB-Gyn. man. Population 6500, excellent hospital facilities, generous salary and all the benefits of corporation assured. Illinois license. Contact S. W. Konarski, M.D., 101 E. Center St., Fairfield, 62837, 618-842-2187. (12)

**FORT MADISON, IOWA:** Opening for 2 FP/GP, OB, Int. in growing industrial city of 16,000 serving 70,000 on Miss. River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, Xlnt, living area, 125 bed accredited hospital. Contact Donald A. Buckert, Sacred Heart Hospital, Fort Madison, Ia. 52627. 319-372-6530. (12)

**FOX LAKE:** Physician wanted to take over practice, equipment and medical building. Physician urgently needed in area. Convenient financial arrangements if necessary. Fifty (50) miles from Chicago in recreational area. Swimming, boating, fishing, hunting and winter sports. Contact: S. L. Fried, M.D., Box 116, Fox Lake 60020. (312) 587-5001. (10)

**JOHNSTON CITY:** Southern Illinois—population 4,000 near I-57. Family practice available. Full equipped office. Surgeon in clinic. Possible partnership available. Hospital 6 miles away. 20 miles to SIU. 100 miles to St. Louis Mo. Contact: Mrs. R. A. Rupprecht, 401 N. Allyn St., Carbondale, 62951 (618) 549-3093 (11)

**OLNEY:** Radiologist to head a new department with another radiologist in a 150 bed hospital with 50 bed addition under construction. Recreational facilities nearby. Community of 10,000. Method of compensation negotiable. Contact Harold Kaseff, Administrator, Richland Memorial Hospital, Olney, 62450. 618-395-2131. (12)

**QUINCY:** Emergency medicine opening—rural mid-western atmosphere—Centrally located for outdoor recreation. Modern 280-Bed Hospital and Trauma Center. 2 M.D.'s looking for a partner or part-time Physician. Guarantee inc. and excellent schedule very flexible. Call collect or write, Thomas Fischer, M.D., Blessing Hospital, Quincy, 62301 (217) 223-5811. (11)

**ROCKFORD:** OB-GYN, Board Eligible or Certified. Will support for Solo Practice or Associate. Practice base in Catholic Hospital. Contact: John E. Tillis, M.D., 5670 East State Street, Rockford, 61108, Phone: (815) 398-4110. (11)

## ILLINOIS is the subject of *Outdoor Illinois Magazine*

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## Pediatric Perplexities

(Continued from page 132)

the heart is necessary in these cases and electrical cardioversion is required if ventricular tachycardia or fibrillation develops.

The management of a child with aminophylline toxicity is supportive as there is no specific antidote. The judicious use of intravenous fluids, continuous monitoring of the patient for cardiac arrhythmias, and control of seizures, is essential for a favorable outcome. ◀

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### Acknowledgement

The authors are indebted to E. Berman, Ph.D., Head, Section of Toxicology, Department of Biochemistry, Cook County Hospital, for the aminophylline levels.

for August, 1976

EKG (Continued from page 155)

Answers: 1. A,E 2. C

The ECG and rhythm strip show complete AV dissociation caused by complete AV block. The sinus node is working well but is not capturing the ventricles at all, i.e. the sinus is completely dissociated. There is no evidence for bundle branch block or acute myocardial infarction. A His bundle recording was performed at the time of temporary pacemaker insertion. This record showed a complete atrioventricular block in the bundle of His. Every P wave was followed by a His potential and every QRS was preceded by a second His potential. Therefore, the area of block was localized to the bundle of His.

There is mounting clinical evidence that lesions in the bundle of His may play a significant role in the development of complete AV block although many of these patients may also have bundle branch block. The treatment here is a permanent demand pacemaker. There was no indication for pressors or digitalis. Quinidine or Procainamide were contraindicated because they might have depressed the lower His or junctional pacemaker and slowed it further. (See P. K. Gupta, et. al., *British Heart Journal* 35:610, 1973 or O. Narula, *HIS BUNDLE ELECTRO-CARDIOGRAPHY*, F. A. Davis 1975).

Major Chicago area hospital has immediate part time opening for a Board Eligible or Certified Dermatologist; 2 hours per week at discretion of physicians; send curriculum vitae in all confidence to:

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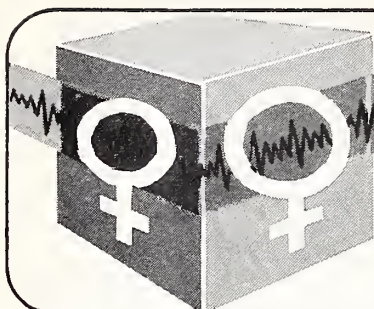
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MRS. HAROLD KEEGAN, Editor

## AMA Auxiliary Meeting Held in Dallas

The Auxiliary to the American Medical Association met in Dallas, Texas. Approximately 800 women registered for its annual convention from June 26-30. The delegates voted on nine final selections in the contest to design a new national seal. Illinois' entry was one of the final choices, however, Ohio's design won. It will now become the new seal for the AMA Auxiliary.

Illinois won several awards during the convention. For the second year in a row our auxiliary won several AMA-ERF awards, including the largest total dollar contributions, with physicians' donations, which totaled over \$146,777.54. St. Clair County won the award for the largest contribution from a county with a membership between 101-200. Their membership is 135.

In answering the roll call by order of entrance into the union, Illinois was the 21st state. Illinois also received awards for the greatest increase in membership, greatest increase in members-at-large, and for establishing a new county society



Standing before the tent set up for a massive barbecue during the Texas convention are Dr. John Ovitz, Prince Consort; Helen Schowengerdt, Bonnie Keegan, Paul Szewczyk, son of Dr. Edward Szewczyk. In front are Charlotte Shumaker and Betty Szewczyk, ISMS Auxiliary President-Elect.

auxiliary. The state with the largest increase in members was Florida.

**Reminder:** In 1978 it will be 50 years for ISMS Auxiliary. Bring any suggestions for a slogan or theme to the Peoria conference or send them to Betty Szewczyk, President-elect ISMS Auxiliary.

The Auxiliary is planning a 50th anniversary cookbook in which you are all urged to participate. Bring your prize recipes to Peoria or mail them directly to Mickey Glatter, Golden Jubilee Planning Chairman, 4729 White Oak Avenue, Rockford, 61111 or to Betty Szewczyk.

### Attention:

### PATCHWORK SYMPOSIUM

September 28, 1976

9 A.M.-3 P.M.

Peoria Hilton

Peoria

The day of the symposium will also be the district meetings for some districts.



## No Slaves But Lots of Action

There were no dancing girls or clanking chains at this slave auction. In fact there wasn't a slave in sight! There was, however, a chicken plucker who was a dead ringer for the Colonel, and a lot of ingenuity. Others included a plant sitter, a jade earring maker, a rose grower, a yard man and a chef. This was the scene at an auction sponsored by members of the Will-Grundy Medical Society Auxiliary to raise funds to purchase a resuscitation Annie to be used to demonstrate cardio-pulmonary resuscitation. When the auction was over, the auxiliary had raised over \$1,000—enough for two Annies.

Dr. James Lambert, the self-introduced chicken plucker and auctioneer, kept the pace brisk and the bids high. One auxiliary member and her husband donated their services as chefs—to prepare and serve an evening meal for a family and guests. There were many other services, culinary wares, and crafts offered at this unusual auction.

On the serious side, Dr. Guy Pandola, president of the Will-Grundy Medical Society, presented two awards from the group for outstanding service. The first went to Dr. Howard Reiser for his dedication in writing a weekly column on health for the Herald-News. The other was given to Dr. Morton Barnett for the Doctors Call Program on WJOL, a talk show which allows those interested to call in and ask questions.



Dr. Lambert, auctioneer, looking very much like the Colonel of chicken fame.

**Reminder:** Please send your home addresses to Jane Swanson, Executive Secretary, ISMS Auxiliary, 122 W. Boston Ave., Monmouth, 61462.

The following counties have been transferred from District 10 to District 9: Alexander, Jackson, Pulaski and Union.

**Mrs. Alan Taylor (Pam)**, Danville, was elected chairman of IMPAC during the ISMS Annual Meeting, April 25. She is the first non-physician chairman in IMPAC's 16 year history.



Carla Wastalu is almost hidden by the hanging fuchsia plant which Ann Arida, president of the Will-Grundy Medical Auxiliary, helps her present.

**ATTENTION**  
**ISMS Auxiliary Convention**  
**April 24-27, 1977**  
**Holiday Inn Mart Plaza, Chicago**



## report

Illinois Society  
American Association of Medical Assistants

# AAMA to Celebrate 20th Anniversary

*The 20th Anniversary Meeting of the American Association of Medical Assistants will convene at the Palmer House in Chicago, **September 13-18, 1976.** Approximately 1,000 medical assistants, educators, students, physicians and other interested individuals will participate in a week of educational programs, workshops and commemorative activities built on the theme, "Change and Challenge—Then and Now." Many prominent health care experts and other speakers from the Chicago area are scheduled to help the nation's first and only professional organization exclusively for medical assistants celebrate two decades of education and service.*

The education program for Thursday, September 16 will analyze "The Quality of Life" as it affects the medical community in its delivery of health care. Effie Ellis, M.D., Co-Director of the Quality of Life Center, City of Chicago and Special Consultant on Community Health, National Foundation/March of Dimes, will lead a discussion of the means by which medicine can help achieve an optimum level of existence during the three major periods of life. Chicagoans scheduled to participate in this analysis are Robert J. Havighurst, Ph.D., Professor of Education and Human Development at the University of Chicago, and John Paton, M.D., Director of Neonatology, Michael Reese Hospital, Chicago.

Following Dr. Ellis' overview, Leo E. Brown, consultant to the American Medical Association and AAMA, will moderate a panel on "Pharmaceuticals and the Quality of Life." Participating in the discussion will be representatives of two major U.S. pharmaceutical firms.

Another dimension of the subject will be ex-



Dr. Ellis

plored in a program arranged by the Rehabilitation Institute of Chicago. "Changing the Quality of Life for the Handicapped" will deal with architectural, emotional and psychological barriers to the self-sufficiency and dignity of the disabled. Participants will include Jack Catlin, Director of *Access Chicago*; Henry B. Betts, M.D., Executive Vice-President and Medical Director of the Rehabilitation Institute; and Dudley Childress, Ph.D., Co-Director of Northwestern University's Rehabilitation Engineering Program, who will explain recent technological advances designed to make a more meaningful and independent existence available to the physically impaired.

The program for Friday, September 17, will be devoted to a look at the future. Prominent AAMA leaders will discuss educational challenges yet to come, and Attorney James J. McNamara, former Assistant Director of AMA's Corporate Law Department, will review "Legal Dilemmas" likely to be confronted.



Dr. Sammons



A presentation of the broad view and some predictions for the years ahead will be made by James H. Sammons, M.D., Executive Vice-President of the American Medical Association, who will speak on "The Future of Health Care."

AAMA President Laura L. Lockhart, CMA-A, Akron, Ohio, will preside at the opening of the 20th Anniversary Convention in the Grand Ballroom of the Palmer House on Monday evening, September 13. Following the presentation of the official program by General Convention Chairman Norma Domanic, New Lenox, Illinois, the 1976 House of Delegates will take up association business under the direction of AAMA Speaker of the House, June B. Hall, CMA-A, of Danville, Illinois. The official slate of officers and trustees will be presented by Nominating Committee Chairman Luella Mitchell of Chicago. On hand to extend greetings will be Illinois State Medical Society President Joseph Skom,

M.D., and Chicago Medical Society President Herschel L. Browns, M.D.

The week's activities, which include many special events commemorating AAMA's 20th year, will culminate with the installation of new officers at the Inaugural Banquet, Friday evening, September 17. President-Elect Joan C. Michaels, CMA-A, Charlotte, North Carolina, will take office as 1976-77 President of AAMA at that time.

Following a Farewell Breakfast on Saturday morning, many medical assistants will depart for London to attend an International Conference for Medical Assistants sponsored by the (British) Association of Medical Secretaries.

Further information about AAMA's 20th Anniversary Convention may be obtained by writing the American Association of Medical Assistants, One East Wacker Drive, Suite 1510, Chicago, Illinois 60601, telephone (312) 944-2722. ◀

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## Obituaries

°°Chamberlain, Iris McKy, Guatamala, formerly of Chicago, died March 27 of this year at the age of 79. Dr. Chamberlain was a 1921 graduate of Washington University in St. Louis, Mo.

°°Christie, James M., Urbana, died this past June at the age of 66. Dr. Christie was the founder of the Christie Clinic, which was named for him, in Champaign, Illinois. Dr. Christie had practiced medicine for more than 50 years after he graduated in 1920, from Northwestern University.

°°Cowen, Oscar J., Miami Beach, Florida, formerly of Chicago, died June 12 in Miami Beach. Dr. Cowen specialized in lung disease and was a pioneer in the study of the effects of asbestos. He was on staffs at Woodlawn Hospital and the Chicago Tuberculosis Sanitarium before his retirement. Dr. Cowen also headed the medical staff at Union Carbide.

°°Darling, Francis M., Casselberry, Florida, passed away in November last year. Dr. Darling was a 1934 graduate of the Chicago Medical School. He was age 80 at the time of his death.

°°Doran, Noreen M. S., Oak Park, passed away May 28, at the age of 83. Dr. Doran was a 1916 graduate of Loyola University Stritch School of Medicine.

°°Ferenczy, Peter, Chicago, has passed away at the age of 60. Dr. Ferenczy was a surgeon on the staff of Edgewater Hospital where he died. He had practiced in Chicago since 1950.

°°Grubb, Kenneth P. Jr., Deerfield, died June 22 of this year at the age of 52. Dr. Grubb graduated from Northwestern University in 1948.

°°Halyama, Gabriel E., Granite City, age 83, died June

2. Dr. Halyama was a 1917 graduate of Loyola University and a member of the 50 year club.

°°Hellrung, Cecelia Marian, Edwardsville, died at the age of 66 on June 1.

°°Huss, John Genery, DuPage County, age 60, passed away June 3. Dr. Huss was a New York Medical graduate of 1942.

°°Levin, Ralph J., Chicago, died June 3 at the age of 37. Dr. Levin was on staff of Louis A. Weiss Memorial Hospital and the University of Illinois Eye and Ear Infirmary. A 1963 graduate of the University of Illinois Medical School, he also was on the medical staff of the Amalgated Clothing Workers of America.

°°Libberton, Raymond C., Dallas, Texas, formerly of Chicago, died May 26, at the age of 104 years. Dr. Libberton was a graduate of Northwestern University, class of 1905.

°°Lindsey, Maude L., Homewood, died June 6, at the age of 83. Dr. Lindsey was a 1924 graduate of Washington University in St. Louis, Mo.

°°Olson, Franklin A., Williams Bay, Wisconsin, formerly from Niles, passed away June 17, 1976, at the age of 67. Dr. Olson was a 1936 graduate of the University of Illinois.

°°Rosen, Jacob, Chicago, passed away June 10, at the age of 80. Dr. Rosen was a 1922 graduate of Stritch School of Medicine, Loyola. Dr. Rosen was on the staffs of Garfield Park Community, Belmont and Walther Memorial Hospitals.

°Indicates ISMS member.

°°Indicates ISMS member and member of the Fifty Year Club.



**RECENT CHANGES**

**federal register**

**Providing Drug Information to Physicians**

**Informational Bulletin #433-76**

**National Health Insurance**

**special report**  
**Malpractice insurance:**

**drug bulletin**

**Health care doesn't need more red tape**

**Drug firms challenge 'MAC' rules**

**Drug Substitution**

**RESEARCH**

**Mailgram**



# THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

**Drug substitution** In most states, pharmacy laws, regulations or professional custom stipulate that your on-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original FDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of significant savings has been produced.

**MAC** Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

**The drug lag** The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## September, 1976

### Cardiovascular Disease

#### CURRENT TRENDS IN CARDIOVASCULAR DISEASE

For: General Practitioners. 3-day tutorial program, Sept. 17, 12 Noon-8:00 PM; Sept. 18, 8:00 AM-5:00 PM; Sept. 19, 8:00 AM-1:00 PM. University of Chicago. Speaker: Oglesby Paul, M.D., Northwestern University Medical School. CME Credit: 20 hrs. AMA Cat. 1; Amer. Soc. Contemporary Med. & Surg. Fee: \$200. Reg. Limit: 200. Reg. Deadline: Sept. 15. Sponsor, contact: John G. Bellows, M.D., Ph.D., Director, American Society of Contemporary Medicine and Surgery, 30 N. Michigan Ave., Chicago 60602. Telephone: (312) 236-4673. Co-sponsor: Center for Continuing Education, University of Chicago.

### Family Practice

#### SEVENTH FAMILY MEDICINE REVIEW

For: Family Physicians. Symposium, Session I, Sept. 26-Oct. 2; Session II, Oct. 17-23 (Two identical sessions). University of Kentucky, Lexington, KY. CME Credit: 48 hrs. AMA Cat. 1; AAFP. Fee: \$295. Reg. Limit: 250. Sponsor: University of Kentucky College of Medicine. Contact: Frank R. Lemon, M.D., University of Kentucky Medical Center, Continuing Education, College of Medicine, Lexington, KY 40506. Telephone: (606) 233-5161.

### Family Therapy

#### WORKING WITH FAMILIES WITH AN ADULT HANDICAPPED MEMBER

For: Physicians and Mental Health Professionals. One-day Workshop. Sept. 3, 9:00 AM-4:30 PM. Chicago. Speaker: Lyle Anderson, M.D., and Darlene Dietz, R.N. CME Credit: 7 hrs. AMA Cat. 1. Fee: \$30. Reg. Limit: 50. Sponsor, contact: Belinda M. Stone, Secretary for Workshops/Conferences, The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Telephone: (312) 440-1414. Co-Sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

### Long-Term Care Drug Therapy

#### AN INTERDISCIPLINARY APPROACH TO RATIONAL GERIATRIC DRUG THERAPY

For: Physicians, Administrators, Dietitians, Nurses, Pharmacists. 2-day workshop, September 9, 9:00 AM-5:00 PM; September 10, 8:00 AM-4:00 PM. Sheraton-O'Hare Motor Hotel, Des Plaines, IL. Speaker: Richard A. Henry, M.D. Fee: \$25. Reg. Limit: 100. Reg. Deadline: August 15. Sponsor, contact: American Pharmaceutical Association, 2215 Constitution Ave., N.W., Washington DC 20037. Attn: Judith D'Brien. Telephone: (202) 628-4410. Co-sponsor: Division of Long Term Care, Health Resources Administration, Dept. of Health, Education, and Welfare.

### Medical Education

#### MEDICAL EDUCATION AND THE CONTEMPORARY WORLD

For: All MD's. 2-day symposium. Sept. 13-14, 9:00 AM-5:00 PM each day. Blackstone Hotel, Chicago. Fee: \$15, \$7 (med. students). Reg. Deadline: Sept. 1. Sponsor, contact: Jane Whitener, Staff Assistant, Univ. of Illinois College of Medicine, Office of Continuing Education Services, 1853 W. Polk St., Room 144, Chicago 60612. Telephone: (312) 996-8025.

### Neurosurgery

#### THIRD ANNUAL POSTGRADUATE COURSE IN BASIC SCIENCE AND CLINICAL REVIEW OF NEUROSURGERY

For: Neurosurgeons, Neurologists, Diagnostic Radiologists. Postgraduate Course. Sept. 7-11, 8:00 AM-5:15 PM each day except Saturday 8:00 AM-12:30 PM. Northwestern University Medical School, Thorne Hall. CME Credit: 35 hrs. AMA Cat. 1. Fee: \$375 (pract. physicians); \$175 (Residents). Sponsor: Northwestern University Medical School, Division of Neurological Surgery. Contact: Jacob R. Suker, M.D., Associate Dean, Postgraduate Education, Northwestern Univ. Medical School, 303 E. Chicago Avenue, Chicago 60611. Telephone: (312) 649-7947.

### Pediatrics

#### PEDIATRIC SURGERY FOR PEDIATRICIANS

For: Pediatricians. Postgraduate course, Sept. 9-10, 8:30 AM-4:30 PM. Children's Memorial Hospital, Chicago. CME Credit: 11 hrs. AMA Cat. 1. Fee: \$100. Reg. Limit: 200. Sponsor: Children's Memorial Hospital. Contact: Jacob R. Suker, M.D., Dept. of Postgraduate Education, Northwestern University Medical School, 303 East Chicago Ave., Chicago 60611. Telephone: (312) 649-7947. Co-sponsor: Northwestern University Medical School, Dept. of Postgraduate Education.

### Plastic Surgery

#### 3rd ANNUAL POSTGRADUATE COURSE IN PLASTIC SURGERY

For: Plastic Surgeons. Postgraduate Course, Sept. 14-16, 8:30 AM-4:30 PM. Northwestern Memorial Hospital, Chicago. CME Credit: 20 hrs. AMA Cat. 1; American College of Surgeons. Fee: \$250. Sponsor, contact: Jacob R. Suker, M.D., Associate Dean of Postgraduate Education, Northwestern University Medical School, 303 East Chicago Ave., Chicago 60611. Telephone: (312) 649-7947. Co-sponsor: American College of Surgeons.

### Psychiatry

#### GENESIS OF THE THERAPIST'S SELF: ITS IMPACT ON PATIENTS AND PEERS

For: Professionals and students in the health field. Lecture Series. September 1, October 6, November 3, January 12, February 2, March 2, and April 13. Forest Hospital, Des Plaines. CME Credit: 2 hrs. per lecture AMA Cat. 1. Fee: Series, \$90; Each lecture, \$15. Reg. Deadline: Entire series before Oct. 6. Sponsor, contact: Leo Jacobs, M.D., Director of Medical Education, Forest Hospital & Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Telephone: (312) 827-8811.

### Pulmonary Disease

#### ACUTE RESPIRATORY FAILURE: MECHANISMS AND MANAGEMENT

For: Internal Medicine—Chest Physicians, Therapists, Nurses. 4-day postgraduate course: televised ICU rounds, small group problems solving workshops. Sept. 29-Oct. 2, 8:00 AM-4:00 PM (Wed., Thurs., & Friday); 8:00-12 noon (Saturday). University of Michigan Medical School, Ann Arbor. Speakers: John G. Weg, M.D., Course Director; James T. Stringfield, M.D., Associate Director. CME Credit: 28 hrs. AMA Cat. 1. Fee: ACCP member, \$160.00; Non-member, \$185.00; Residents, Interns, Nurses, Therapists, \$125. Reg. Deadline: None (may register at course). Sponsor, contact: American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068. Attn: Mr. Dale Braddy. Telephone: (312) 698-2200. Co-sponsor: University of Michigan Medical School.

### Sexual Therapy

#### INTEGRATION OF SEXUAL THERAPY INTO ONGOING PSYCHOTHERAPY

For: Physicians and Mental Health Professionals. 2-day workshop, Sept. 17-18, 9:00 AM-4:30 PM. Norris Center, Evanston, Illinois. Speaker: E. Lee Doyle, Ph.D., Private Practice, Dallas, Texas. CME Credit: 14 hrs. AMA Cat. 1. Fee: \$70. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Attn: Belinda M. Stone, Secretary for Workshops/Conferences. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

## October, 1976

### Anesthesiology

#### REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING

For: All MD's. 5 day course. Oct. 4-8. CME Credit: 40 hrs. AMA Cat. 1. Fee: \$300. Reg. Limit: 8. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Telephone: (312) 733-2800.

### Couples' Therapy

#### MULTIPLE COUPLES' THERAPY

For: Physicians and Mental Health Professionals. One-day workshop, October 1, 8:30 AM-5:00 PM, Chicago. Speaker: Charles Kramer, M.D., and Jeannette Kramer, F.I.C./C.F.S. CME Credit: 8 hrs. AMA Cat. 1. Fee: 30. Reg. Limit: 50. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Attn: Belinda M. Stone, Secretary for Workshops/Conferences. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

### Emergency Medicine

#### 1976 ACEP/EDNA SCIENTIFIC ASSEMBLY

For: Emergency Physicians and Nurses. Scientific Assembly. October 11-15. Superdome, New Orleans, Louisiana. Fee: varies. Sponsor, contact: American College of Emergency Physicians and Emergency Department, 241 E. Seginaw, East Lansing, MI 48823. Attn: Martha J. Muth, CME Coordinator. Telephone: (517) 332-6544.

### Family Practice

#### SEVENTH FAMILY MEDICINE REVIEW

For: Family Physicians. Symposium, October 17-23. University of Kentucky, Lexington, KY. CME Credit: 48 hrs. AMA Cat. 1; AAFP. Fee: \$295. Reg. Limit: 250. Sponsor: University of Kentucky College of Medicine. Contact: Frank R. Lemon, M.D., University of Kentucky Medical Center, Continuing Education, College of Medicine, Lexington, KY 40506. Telephone: (606) 233-5161.



## Oncology

### SECOND ANNUAL POSTGRADUATE SEMINAR— THE MANAGEMENT OF COMMON NEOPLASMS: HEAD, NECK, GYNECOLOGICAL AND ROLOGICAL TUMORS

For: Physicians, graduate students in specialties designated—Obstetrics & Gynecology, Urology, Oncology. Postgraduate Seminar in Oncology (2½ days), Oct. 1 & 2, 8:30 AM-5:00 PM; Oct. 2½, 8:30 AM-12 noon. Northwestern Memorial Hospital, Chicago. **CME Credit:** 17 hrs. **AMA Cat. 1. Fee:** \$150. **Reg. Limit:** 00. **Reg. Deadline:** October 21. **Sponsor, contact:** Northwestern University Cancer Center, Northwestern University Medical School, 303 E. Chicago Avenue, Chicago 60611. Attn: John S. Schweppe, M.D., Chairman, Cancer Center Education Committee. Telephone: (312) 649-8674 or 642-9294.

## Otolaryngology

### ANNUAL OTOLARYNGOLOGIC ASSEMBLY

For: Physicians in specialty. Assembly-1 week, October 6-22, 8:00 AM-5:00 PM. University of Illinois, Eye and Ear Infirmary, Chicago. **Speaker:** Emanuel M. Skolnik, M.D., Chairman of the Assembly. **CME Credit:** 42 hrs. **AMA Cat. 2. Sponsor, contact:** Dept. of Otolaryngology, University of Illinois, 1855 W. Taylor Ave., Chicago 60612. Attn: Mrs. Evelyn Seman. Telephone: (312) 996-6582.

## Perinatal Medicine

### SYMPOSIUM ON PERINATAL MEDICINE— CLINICAL AND BIOCHEMICAL ASPECTS

For: Pediatricians, Obstetricians, Gynecologists, Researchers, Medical Students, Nurses. Two-day Symposium, October 25 & 26, 8:30 AM-5:15 PM. Christ Hospital, Oak Lawn. **Speakers:** Nationally/Internationally known figures in Perinatal Medicine. **Fee:** \$50. **Reg. Limit:** 300. **Reg. Deadline:** Sept. 15. **Sponsor, contact:** Christ Hospital, 4440 West 95th St., Oak Lawn, IL 60453. Telephone: (312) 425-8000 ext. 5690. Attn: Dr. M. Rathil or Dr. S. Kumar. Co-sponsor: Mead Johnson Laboratories.

## Psychiatry

### GENESIS OF THE THERAPIST'S SELF: ITS IMPACT ON PATIENTS AND PEERS

For: Professionals and students in the health field. Lecture Series, October 6, November 3, January 12, February 2, March 2, and April 13. Forest Hospital, Des Plaines. **CME Credit:** 2 hrs. per lecture **AMA Cat. 1. Fee:** Series, \$90; Each lecture, \$15. **Reg. Deadline:** Entire Series before Oct. 6. **Sponsor, contact:** Leo Jacobs, M.D., Director of Medical Education, Forest Hospital & Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Telephone: (312) 827-8811.

## Varied—Multidiscipline

### CARLE FOUNDATION DAY

For: General Practitioners. Lecture Series and Evening Guest Speaker, October 27, Ramada Inn, Champaign, Illinois. **Fee:** None. **Sponsor, contact:** Carle Foundation and Carle Clinic, Dept. of Neurology, 602 W. University Ave., Urbana, IL 61801. Attn: James B. Worrell, M.D. Telephone: (217) 337-3180.

## November, 1976

## Anesthesiology

### REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING

For: All physicians. 5-day course, November 15-19. Chicago. **CME Credit:** 40 hrs. **AMA Cat. 1. Fee:** \$300. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Eugene Meyer. Telephone: (312) 733-2800.

## Diabetes Mellitus

### NEW HORIZONS, 1976

For: Physicians and allied health professionals. One day symposium, November 21, 9:00 AM-3:15 PM. Pick-Congress Hotel, Chicago. **Main Speaker:** Dr. Donald F. Steiner. **Fee:** \$15 for physicians not members of American Diabetes; \$10 for allied health prof. not members. **Reg. Deadline:** Nov. 18. **CME Credit:** 6 hrs. **AMA Cat. 1. Sponsor, contact:** American Diabetes Association, Greater Chicago and Northern Illinois Affiliate, 620 N. Michigan Ave., Chicago, IL 60611. Attn: Florence Narodick. Telephone: (312) 943-8668.

## Early Breast Cancer Detection Methods

### 2ND MID AMERICAN BREAST CANCER SYMPOSIUM

For: Physicians. Symposium, Nov. 5-6, 8:30 AM-5:30 PM. Concourse Hotel, Madison, Wisconsin.

**Speaker:** Dr. Robert Egan. **CME Credit:** 12 hrs. **AMA Cat. 2. Fee:** \$75. **Reg. Limit:** 300. **Reg. Deadline:** Oct. 15. **Sponsor, contact:** Wisconsin Breast Cancer Detection Foundation, Inc., 7803 Mineral Point Rd., Madison, Wisconsin 53717. Attn: Paula Hobbs. Telephone: (608) 831-2300. Co-sponsor: National Association for Cancer Detection.

## Marital Therapy (Divorce)

### FOURTH ANNUAL FALL CONFERENCE: CREATIVE DIVORCE

For: Physicians and mental health professionals. Two-day workshop, November 11-12, 9:00 AM-4:30 PM. Norris Center, McCormick Auditorium, 1999 Sheridan Road, Evanston. **Speaker:** Mel Krantzler, M.S., Dir. Creative Divorce Nat'l Counseling Center, San Rafael, CA. **CME Credit:** 14 hrs. **AMA Cat. 1. Fee:** \$70. **Sponsor, contact:** The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

## Pediatric Neurology

### CLINICAL ADVANCES IN PEDIATRIC NEUROLOGY

For: Pediatricians, Neurologists. 2-day continuing education course, November 8-9. Holiday Inn Central, Milwaukee, Wisconsin. **Speaker:** Jerome V. Murphy, M.D. **CME Credit:** 12 hrs. **AMA Cat. 1. Fee:** \$125. **Reg. Limit:** 120. **Sponsor, contact:** Medical College of Wisconsin, Office of Continuing Education, 561 N. 15th St., Milwaukee, Wisconsin 53233. Attn: Edwin O. Hirsch, M.D. Telephone: (414) 272-5450, ext. 335.

## Psychiatry

### ILLINOIS PSYCHIATRIC SOCIETY 3RD ANNUAL FALL WEEKEND MEETING

For: Psychiatrists and other interested professionals. Symposia, workshops, lectures and film presentations. November 5-7, 6:00 PM Friday-Sunday noon. O'Hare Marriott, Higgins and Cumberland Roads, Chicago. **CME Credit:** 15 hrs. **AMA Cat. 1. Fee:** \$30. **Reg. Deadline:** November 1. **Sponsor, contact:** Illinois Psychiatric Society, 55 East Monroe, Suite 3510, Chicago, IL 60603. Attn: Wendy Smith. Telephone: (312) 782-1654.

### GENESIS OF THE THERAPIST'S SELF: ITS IMPACT ON PATIENTS AND PEERS

For: Professionals and students in the health field. Lecture Series, November 3, January 12, February 2, March 2, and April 13. Forest Hospital, Des Plaines. **CME Credit:** 2 hrs. per lecture **AMA Cat. 1. Fee:** Series, \$90; Each lecture, \$15. **Reg. Deadline:** Entire Series before Oct. 6. **Sponsor, contact:** Leo Jacobs, M.D., Director of Medical Education, Forest Hospital and Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Telephone: (312) 827-8811.

## Laryngology and Bronchoesophagology

### COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY

For: Physicians. 6 day course, November 1-6, 8:00 AM-5:00 PM. Eye and Ear Infirmary, Chicago. **Speaker:** Paul H. Holinger, M.D. **CME Credit:** 45 hrs. **AMA Cat. 2. Fee:** \$350. **Reg. Limit:** 20. **Sponsor, contact:** University of Illinois, Dept. of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Ave., Chicago, IL 60612. Attn: Mrs. W. B. Wickland. Telephone: (312) 996-6582.

## CME Planning Aids

ICCME continually develops a variety of "how-to" material for CME Planners—DME's, program chairmen of hospitals and medical societies (both specialty and geographic), and others. All items are FREE to Illinois physicians and CME sponsors.

To learn what's currently available, request the "CME Planning Aids Order Form"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Two Unusual CME Planning Aids . . .

. . . can help you plan better programs, whether in hospital or medical society:

"Case-Discussion & Problem-Solving" details a tested method for using case-discussion that generates enthusiastic interest among MD's.

"Planning CME Programs that Fit Staff Needs: Patient Problem-Inventory" describes how to gather data on the kind of patient problems that a given group of physicians (a) see often and (b) feel a need to learn more about. Proven in use, this method taps physicians' basic motivations to continue learning.

Both are FREE to Illinois physicians and CME planners, upon request. To others, a charge is necessary to cover cost of printing, postage, & mailing: "Case-Discussion," \$2.00; "Patient Problem Inventory," \$2.00.

For your copy of either (or both), write or call:

Illinois Council/CME  
55 E. Monroe, Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Your Personal Learning Plan

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Any Illinois physician (MD or DO) may have a copy FREE upon request; simply write "Personal Learning Plan" on your prescription form, and mail to ICCME (address above). To all others, the cost is \$1.00/copy postpaid (90¢ each in quantities of 100 or more).

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**EXCELLENT OPPORTUNITY AND ENVIRONMENT**—Physician needed to practice general medicine in large outpatient clinic and 38 bed fully accredited hospital. Must possess empathy toward college age population. Salary negotiable, excellent fringe benefits. Contact L. W. Combs, M.D., Purdue Student Hospital, West Lafayette, IN 47907, 317-749-2441. Equal access/equal opportunity employer.

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**FAMILY PRACTITIONER WISHES ASSOCIATE** who is Board certified or Board eligible in family practice to join family practice. Located in Waterloo, Iowa, a northeast Iowa community of 75,000. All records dictated on the Problem Oriented Medical Records System. Ronald R. Roth, M.D., 611 Black's Bldg., Waterloo, Iowa 50703.

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BASIC DERMATOLOGY, One Week, October 11  
BASIC ELECTROCARDIOGRAPHY, One Week, October 18  
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# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

### Fall Series of Blue Shield Workshops Scheduled

Illinois Blue Shield is conducting a series of workshops for medical assistants in Cook County. The series will begin October 6 and will continue through November 18, 1976.

Workshops for October and November are:

Wed., Oct. 6	Holiday Inn	Harvey
Wed., Oct. 13	Sheraton Inn	Oak Lawn
Thurs., Oct. 14	Sheraton Inn	Oak Lawn
Wed., Oct. 20	Holiday Inn	Evanston
Wed., Oct. 27	Howard Johnson Higgins Road	Chicago
Wed., Nov. 3	Arlington Pk. Towers	Arlington Hts.
Wed., Nov. 10	McCormick Inn	Chicago
Wed., Nov. 17	Continental Plaza Hotel	Chicago
Thurs., Nov. 18	Continental Plaza Hotel	Chicago

Letters inviting medical assistants to attend the workshop meetings were mailed September 7 to physicians' offices in Cook County. Reservation forms were enclosed with the meeting schedule, and should be returned promptly to the Professional Relations Department of Blue Shield. For additional information on the workshops, please write or phone Loretta O'Donnell, Professional Relations Department, Blue Cross-Blue Shield, 233 North

Michigan Avenue, Chicago, Illinois 60601. Phone (312) 661-2964.

The Professional Relations Department is conducting the workshops and staff members are serving as instructors. Separate classes are held for experienced medical assistants and for those having less than one year's experience.

Those wishing to attend the meetings have a choice of registering for either the morning or afternoon program. Registration for the morning session begins at 8:30 AM. Workshops start at 9:00 AM and continue to 12:00 at which time luncheon will be served. The program is repeated after the luncheon. Afternoon sessions will adjourn at 4:30 PM. Those who attend either workshop are invited to the luncheon.

The workshop programs will include a review of our revised Medical Assistants Handbook containing current information on a number of special contracts, as well as instructions on how to complete a Physician's Service Report so delays in processing claims can be prevented. Medical assistants are requested to bring their copy of the Handbook to the Workshop. Time will be allowed for questions. Workshops will also include discussions of Medicare coverage and how to complete Medicare forms.

### Submitting Claims for Patients Enrolled in Reciprocity Program

Reciprocity is a system that enables Illinois physicians to bill and receive payments directly from Illinois Blue Shield for services to out-of-state members enrolled in this special program.

Payment under the Reciprocity Program is made on the 100% Usual and Customary basis. A physician receives 100% of his usual fee when his fee is "within the range of usual fees charged by physicians of similar training and experience within the same geographic area" for services covered under the Reciprocity contract. Because the claims will be processed by Illinois Blue Shield without the delay for membership verification, the physician receives prompt payment.

Members enrolled in the program will be easily identified by the special identification card which has a double-pointed red arrow in the upper left corner and a series of three numbers preceded by the letter "N" within the arrow. The number indicates the Home Plan of the member.

When a physician treats a patient having this special card, he files for benefits the same way he would for an Illinois member with one exception: Both the letter "N" and code number in the arrow, plus the subscriber's identification must be entered on the Group and Subscriber line of the Physician's Service Report. When the report is completed, send it to Illinois Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601.

Thank you for your assistance.

## ASK BLUE SHIELD ... ABOUT MEDICARE

### Notifications of Changes in Status of Laboratories

Notification of changes in status for the following independent laboratories has been received from the Social Security Administration regarding Medicare program participation, withdrawals from the program, or changes in approved specialties and subspecialty procedures:

#### Recently Certified for Participation:

Flossmoor Commons Medical Laboratory, 3233 Vollmer Road, Flossmoor (Provider Number 14-8314) has been approved by the Illinois Department of Public Health effective June 30, 1976. The laboratory is approved to perform procedures in Bacteriology, Parasitology, Serology, Chemistry, Hematology and Diagnostic Cytology.

Roseland Clinical Laboratory, Inc., 11418 South Michigan Avenue, Chicago (Provider Number 14-8313) has been approved effective February 5, 1976. The laboratory is approved to perform procedures in Bacteriology, Parasitology, Serology, Chemistry, Blood Group and Rh Typing, Diagnostic Cytology and EKG services.

#### Closed or Change in Ownership:

Medi-Comp Laboratory of South Cook County, 1010 Dixie Highway, Chicago Heights (Provider Number 14-8306) closed effective June 1, 1976. No payment can be made under the health insurance program for services rendered on or after June 1, 1976.

Tenn Clinical Laboratory, Inc., 1057 West Argyle, Chicago (Provider Number 14-8246) was closed effective May 31, 1976. No payment can be made under the health insurance program for service rendered on or after that date.

Physicians and Surgeons Clinical Laboratory, 6710 West North Avenue, Chicago (Provider Number 14-8132) has been purchased by Lancet Medical Industries, effective May 31, 1976. No payment can be made for services after that date.

Reymar Clinical Laboratory, 6032 South Halsted Street, Chicago (Provider Number 14-8269) closed effective June 1, 1976. No payment can be made for services rendered on or after that date.

Sarian Medical Laboratories, Inc., 6259 South Archer Avenue, Chicago (Provider Number 14-8011) changed ownership effective June 1, 1976. The laboratory meets the requirements for coverage of its services under Medicare for the following tests and procedures: Bacteriology, Parasitology, Serology, Chemistry, Hematology and EKG services.

#### Changes in Approval of Specialty or Subspecialty Procedures:

University Laboratory, 5 South Wabash, Chicago (Provider Number 14-8070) is no longer approved by the Illinois Department of Public Health to perform Chemistry procedures. No payment can be made for Routine Chemistry or Clinical Microscopy procedures effective September 1, 1976. The laboratory is approved to perform Serology, Hematology and EKG services.

McGregor Laboratories, 6144 West Roosevelt Road, Oak Park (Provider Number 14-8144) is no longer approved to perform Blood Grouping and Rh Typing effective September 1, 1976. The laboratory is approved to perform Serology, Chemistry, Hematology and EKG services.

Winnetka Clinical Laboratory, Inc., 725 Elm Street, Winnetka (Provider Number 14-8014) is no longer approved to perform the procedures of Blood Grouping and Rh Typing effective September 1, 1976. The laboratory is approved to perform procedures in Chemistry, Serology, Hematology and EKG services.

Twenty-Sixth Street Laboratory, 3814 West 26th Street, Chicago (Provider Number 14-8262) is no longer approved to perform procedures in Parasitology and 330-Chemistry effective September 1, 1976. The laboratory is approved for Serology, Hematology, Blood Grouping and Rh Typing and Diagnostic Cytology.

Francisco Medical Laboratory, 9450 South Francisco, Evergreen Park (Provider Number 14-8179) is no longer approved to perform procedure 330-Chemistry effective September 1, 1976. The laboratory is approved for Serology, Hematology and EKG services.

Chatham Avalon Clinic Laboratory, 8222 South Martin Luther King Jr. Drive, Chicago (Provider Number 14-8060) is no longer approved to perform procedure 330-Chemistry effective September 1, 1976. The laboratory is approved for Serology, Hematology and EKG services.

Alpha Clinical Laboratories, Inc., 1601 East 53rd Street, Chicago (Provider Number 14-8309) has been approved to perform Diagnostic Cytology effective June 2, 1976. The laboratory is also approved to perform Serology, Chemistry, Hematology, Blood Group and Rh Typing, Rh Titers, Radiobioassay and EKG services.



# Editorials



## *Ambulatory Surgery*

Many surgeons are showing increasing interest in surgicenters where their patients can be treated for one day surgery. These ambulatory centers will help to lower the cost of surgery in a hospital environment. Their acceptance will depend upon the willingness of the third party health insurance companies to pay for this type of care.

Ambulatory surgery is not new. Until 35 years ago almost all minor and not so minor surgical procedures including sigmoidoscopic examinations were done in the doctor's office. It was successful and inexpensive. Then came insurance which paid for hospital but not office care. It made little sense except to exclude the entrepreneurs of our profession.

Meanwhile hospitals updated their operating room costs to include the cost of surgical nurses, anesthesiologists, medications and other incidentals. Some hospitals charge \$75.00 and up for the first half hour in the operating room, which in many instances is spent in preparing the patient. All of this received additional credibility with the growing problem of malpractice liability. At the hospital it was said that the patient received maximum care which he could not get in the physician's office.

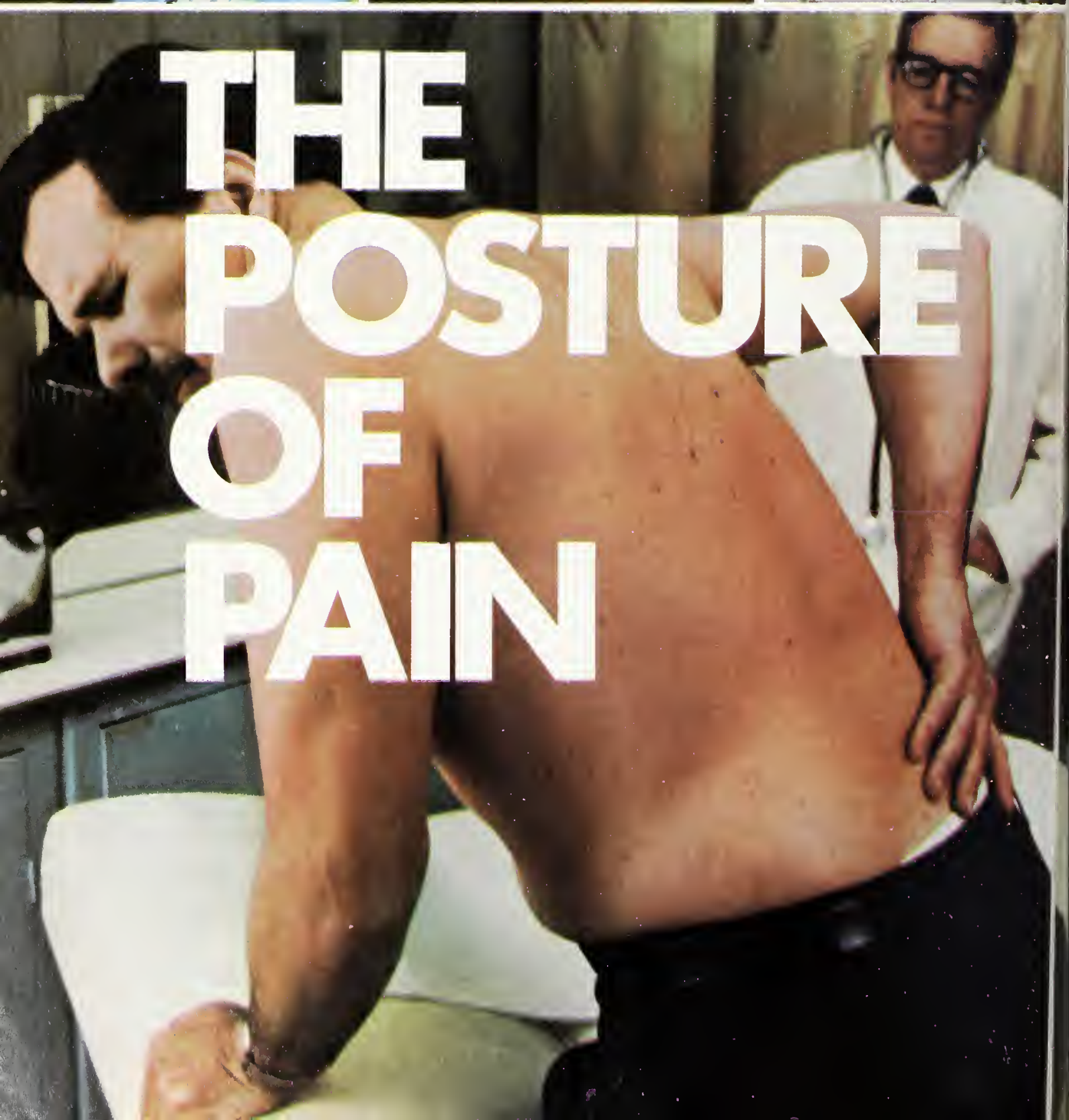
The quality and performance of the surgical day centers must match the care provided by hos-

pital in-patient and out-patient units to be successful. These facilities should not be parts of large shopping centers unless they are in separate medical buildings. Although there are no figures to my knowledge as to how much money might be saved, it is reasonable to assume that it will be considerable.

It is surprising the variety of surgical procedures that are being done in established surgicenters. But it is the patient who will benefit, especially when they need biopsies or when a wart or cyst must be removed. Some of the ambulatory surgical centers report charges that are 50% less than hospitals for comparable procedures.

These centers will become popular if they are run by ethical private physicians on a business like basis. Each should be an independent center so as to be spared the red tape of hospitals. Meanwhile, the patient does not disrupt his normal life or aggravate feelings of apprehension. He misses very little work or school. For children there is less trauma or family disturbance.

T. R. Van Dellen, M.D.  
*Editor*



# THE POSTURE OF PAIN





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# The promise of Soma in the "low-back" patient: relief of discomfort... improved function

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## **Soma<sup>®</sup> 350** (carisoprodol) 350 mg tablets for measurable relief

**Indications:** Carisoprodol is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.

**Contraindications:** Acute intermittent porphyria and allergic or idiosyncrotic reactions to carisoprodol or related compounds such as meprobamate, mebutamate, tybamate.

**Warnings:** Idiosyncrotic Reactions: Rarely, extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion and disorientation have appeared within minutes or hours of the first dose.

These usually subside in several hours but supportive and symptomatic therapy, including hospitalization, may be necessary.

**Pregnancy and Lactation:** Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers (concentrations in breast milk are two to four times that in plasma), or women of childbearing potential.

**Children Under Twelve:** Not recommended.

**Potentially Hazardous Tasks:** Driving a motor vehicle or operating machinery.

**Additive Effects:** Effects of carisoprodol and alcohol, other CNS depressants or psychotropic drugs may be additive.

**Drug Dependence:** Use cautiously in addiction-prone patients.

**Precautions:** To avoid excess accumulation, use caution in patients with compromised liver or kidney function.

**Adverse Reactions:** **Central Nervous System:** Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia, idiosyncrotic reaction (see "Warnings").

**Allergic or Idiosyncrotic:** In previously unexposed patients, these are usually seen after 1-4 doses and include rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction to meprobamate. Asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, swelling eyes, hypotension and anaphylactoid shock may be manifestations of severe reactions. In such cases, stop carisoprodol and initiate appropriate treatment (e.g., epinephrine, antihistamines, corticosteroids).

**Cardiovascular:** Tachycardia, postural hypotension, facial flushing.

**Gastrointestinal:** Nausea, vomiting, hiccup, epigastric distress.

**Hematologic:** Leukopenia and pancytopenia (on carisoprodol plus other drugs).

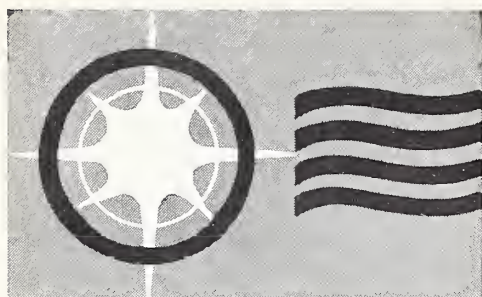
**Usual Adult Dosage:** One 350 mg tablet three times daily and at bedtime.

**Overdosage:** Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdose of carisoprodol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

**Before prescribing, consult package circular or latest PDR information.**

1. Hindle, T.H. III: Calif. Med. 117:7 (Aug.) 1972. 2,3. Unpublished Data on file, Medical Department, Wallace Laboratories, Cranbury, N.J.

UNIVERSITY OF MARYLAND  
BALTIMORE



## membership forum

### Upon Reaching 93—Whew!

I little thought that I'd live to be  
Still rattling around at age ninety-three.  
To what do I owe my longevity?  
Well—let me see.  
It can't be nutrition, for  
Ideas of nutrition when I was a child  
Would drive the modern medic quite wild.

There was cream that was whipped  
And cream that was soured.  
Ice cream, clabber and cheese cake oft were  
devoured.  
Fat geese, livers and cracklings and egg yoks  
galore.  
I shudder to think of it. I won't list any more.  
Of course in those days no one had heard of  
cholesterol  
But all the time the sneaky villain was taking its  
toll.

There was no one around like Charles Kuralt  
To warn that our diet was sadly at fault.  
If I had known then I would live so long  
I'd have tried to avoid doing everything wrong.

Hedwig L. Loeb  
July, 1976

Dear Editor and Readers:

After the criticism which has been heaped upon the profession of medicine for being managed like a cottage industry, I feel impelled to note that the Industrial Revolution wiped out the former cottage industries (TIME, July 14, 1975, p. 54).

My hope is that our social planners will not wipe out medical cottage industry and create "dark Satanic mills" to process "health" as a "commodity." I was reminded of this by a recent advertisement sent out by American Express. Whatever the true artistic value of the items may be, the promotion material took pains to point out how the items were created by expert silver-

smiths in India, working in the fashion of "cottage industries" of another age, with the kind of old world care and pride of "cottage industries" as the only way such true artistic excellence and lasting beauty could be realized.

Sincerely,  
David A. Rothstein, M.D.

Dear Dr. Van Dellen:

I am impressed with the article "Evolution of Regionalized Perinatal Care in Southern Illinois" by Dr. William Hamilton, published in June, 1976 issue of *Illinois Medical Journal*.

The intermediate care perinatal centers will bridge the gap between the general care and tertiary care centers. At present, almost all high risk newborn babies with minor or major problems are transferred from the general care centers to tertiary care centers, whereas some larger institutions, which are functioning as "intermediate care centers," (though not designated as such) transfer the babies with major problems (as ventilator care, cardiac catheterization, major surgery) to the tertiary care areas. Initially institutions providing perinatal care were to be classified into three categories. Even though some larger institutions have opted to be designated as Intermediate Care Perinatal Centers, to my knowledge, no institution so far has been designated as such. Though tertiary care perinatal centers are providing excellent care to the babies after the transfer and are encouraging the transfers at earlier stages, a better approach would be to enhance the level of care provided to mothers and babies in the primary care hospitals. Various measures implemented by Dr. Hamilton in Carbondale area, and in addition recognition and funding of intermediate care perinatal centers will be helpful not only in reducing the mortality and morbidity but better in health care delivery and better rapport with parents.

Sincerely,  
Y. Surainder, M.D.  
Director of Neonatology  
Illinois Masonic Medical Center



## Guest Editorial

# Illinois CME Accreditation

*In 1972, ISMS invited the State's eight medical schools to join in a unique co-operative venture between profession and professional school—the Illinois Council on Continuing Medical Education. ICCME has worked quietly but effectively throughout the state since that time. To insure that all ISMS members know about ICCME services, we have arranged for members of that Council's Board to write a series of editorial reports. This is the seventh in that series.*

November 15, 1975, mandatory CME was enacted into law with a new section, amending the Medical Practice Act. In essence this amendment reads as follows:

"The Department (of Registration & Education) based on the written recommendation of the Examining Committee, shall promulgate mandatory requirements of continuing education for persons licensed pursuant to this Act."

Illinois became the fifth state to enact mandatory CME, joining Michigan, Ohio, Washington, and Wisconsin.

The Illinois State Medical Society, in anticipation of this eventuality, joined with the eight Medical Schools in Illinois in the establishment of a Statewide Council on Continuing Medical Education, which was later chartered in 1972 as a non-profit educational organization, the Illinois Council on Continuing Medical Education (ICCME). The foresight and wisdom in creating this council proved prophetic.

In its leadership role, ISMS has assumed the responsibility for State level accreditation of local CME programs through the Council on Education and Manpower and its Committee on Accreditation. It is the function of ICCME to investigate and evaluate Illinois CME Accreditation Programs of institutions and organizations offering CME learning activities which fit the AMA definition of a "planned program" and carry Category 1 credit toward the Physicians Recognition Award (PRA).

The booklet, "The Illinois Accreditation Program for Continuing Medical Education" (available free upon request) contains detailed information, concerning accreditation procedures and spells out five Criteria for CME accreditation. At the core of these Criteria is the principle of Peer Review, a concept which deserves further elaboration.

### Peer Review—The Key to CME

In the evaluation of physician performance, the focus is upon the community hospital. More than two-thirds of hospital patients in this coun-

try are treated in community hospitals, which are the ideal centers for continuing medical education and the proper locus for Peer Review.

Local peer review programs must be designed to avoid conflict of interest and professional friction. It has been suggested that the responsibility for establishing educational peer review be under a physician who is not a member of the active medical staff. Other key individuals in a peer review program are the medical records librarian, the head of the nursing services, and the hospital administrator or his representative, all of whom are involved in the quality control of medical care. Once physicians appreciate the necessity for evaluating the quality of medical care, it will be possible to introduce related concepts, such as peer review for educational purposes. Where possible, the use of a computerized data collection and retrieval system, such as PAS-MAP, will greatly facilitate the evaluation.

Standards of medical care, indices of physician competence, and the criteria for peer review should be arrived at by the local physicians to meet the special needs of their community. Local participation at the "grassroots level" in the development of standards in community hospitals may become the basis for the emergence of statewide standards. It is imperative that the medical staff carefully evaluate the criteria in this learning process.

The criteria developed for the delivery of adequate care must be relevant to the individual patients, and to the community, as well as the physician-providers. This involves a consideration of the process of care, the outcome of care, and efficiency. While not synonymous with the process of care which deals with the proper diagnosis and management of the patients' problems and symptoms, efficiency is more concerned with the economic aspects of health care.

The criteria must be clearly stated, meaningful, and achievable. The standards of care developed by the JCAH for various diagnoses and problems

*(Continued on page 252)*

DISPENSARY

# Tough...

(even when  
pain calls  
for codeine)



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# Unchecked Regulatory Power Threatens All

Just about every aspect of our lives—and, increasingly, the physician's professional life—is being invaded and pervaded by a government within the federal government.

In many respects, this inner government enjoys so much autonomy that it stands outside—as well as within—the government as conceived by the Founding Fathers, though officially it is a part of the Executive branch.

We refer to the regulatory agencies, which have been multiplying at the rate of more than one a year over the past decade.

Their power over the people is in inverse relationship to their public accountability. Unlike members of Congress and the President their leaders are not elected at the polls. Unlike the federal judiciary, they offer no uniform route of appeal from their decrees.

Although the agency heads are appointed by the President and confirmed by Congress, the actual regulations are likely to be prepared by anonymous civil servants. In addition to being executive arms, the agencies are also powerful legislators and even judges.

Last year the regulatory logbook—the *Federal Register*—carried 60,221 pages of single spaced fine print, a “gain” of some 14,000 pages over 1974. Those hillocks of paper are virtually as much law as any act of Congress.

The regulations fought by the American Medical Association—the original two sets on Utilization Review, for example, and the Maximum Allowable (Drug) Cost rules—did not just implement law, but created it.

Why have the agencies gained such a vast amount of law-making power?

One reason is that Congress—in its crush of work—enacts loose, pliant legislation that the regulators can mold like putty. Another reason is the Administration Procedure Act, whose ground rules for the agencies are amenable to being either over-utilized or evaded—whichever suits the fancy and ambition of the regulator.

Over-regulation has been getting plenty of apprehensive attention lately—from the media, the business world, the White House, and also in the Congress that enabled the power to grow as it has. The American Enterprise Institute for Public Policy Research has just announced the establishment of a research center—with a blue-ribbon advisory council—to study government regulation.

But the first general need is to get the Administrative Procedure Act amended, so that the regulators will have to pay more respect to orderly and orthodox government processes and to the regulated.

Bills to strengthen the process of citizen input into new regulations are receiving attention in both houses of Congress. AMA bills are among those receiving consideration. In the House of Representatives a bill (HR 12048) sponsored by Representative Walter Flowers of Alabama is ready for floor action.

Physicians are acutely aware of the impact of unrealistic regulations on the quality of medical care under federal programs. The Flowers bill and others represent a real hope for improving the regulation-writing process. ◀



# *Abstracts of Board Actions*

June 12-13, 1976

Chicago

## **License Renewal Form**

ISMS will take legal steps to prevent the Department of Registration and Education (R & E) from bringing action against physicians who refuse to provide information pertaining to professional liability suits as requested on the license renewal form.

Although legal counsel advised the Board of Trustees that R & E most likely has authority to seek certain information about malpractice suits, due process must be provided before a physician is denied a license. Since Illinois statutes do not outline what steps R & E must take to guarantee due process, the Board is concerned that the Department may use the information to harass physicians. Despite inquiries, R & E Director Ronald Stackler has failed to indicate any reasonable plan for using the information.

While ISMS will act immediately, results may not be available prior to the June 30 deadline for submission of the renewal form. Members who have already provided the data to R & E will be urged through ACTION REPORT to contact ISMS if they experience an incident involving abuse of the information.

## **Triplicate Prescription Forms**

In another legal action, ISMS will attempt to strike down a Dangerous Drugs Commission regulation requiring triplicate prescription forms for all Schedule II controlled substances. Informed that all possible means had been used to modify this regulation without success, the Board directed legal counsel to seek injunctive relief.

## **Physician-Owned Insurer Begins Operations**

The new physician-owned insurance company—the Illinois State Medical Inter-Insurance Exchange—is in operation. As of June 11, some 2,600 physicians had remitted their one-time surplus contributions needed to capitalize the company and the Illinois Insurance Department has issued a "certificate of authority" which allows the company to begin writing professional liability coverage.

Paul Singer, former vice president and senior actuary of Continental Casualty Company's Corporate Actuarial Department, was named president of Illinois State Medical Insurance Service, Inc., the operating arm of the new insurance company.

## **House of Delegates Meetings**

The first interim session of the ISMS House of Delegates will be held November 6 and 7 at the new Continental Regency Hotel in Peoria. Deadline for resolutions to be printed in the Illinois Medical Journal is September 4; final cutoff date for resolutions to be considered by this session of the House is October 9.

The 1977 annual meeting of ISMS will be April 24-27 at the Holiday Inn Mart Plaza, a new hotel being built on top of the new apparel mart just west of Chicago's Merchandise Mart.

## **Health Service Agencies**

ISMS is supporting the United Health Systems Agency which is seeking designation as the health systems agency for suburban Cook and DuPage counties under national health planning regulations. The United group was developed by the Chicago and DuPage County medical societies along with the local comprehensive health planning agency and the Suburban Communities Health Planning Organization. ISMS has urged HEW Secretary F. David Matthews to reject the application of the Suburban Cook-DuPage County Health Systems Agency which also is seeking HSA designation for the area.

In a related action, the Board adopted the following recommendations of its Strategy Committee on State Government:

- (1) Field staff will help insure that physicians are among local HSA recommendations to the State Health Coordinating Council.
- (2) A meeting should be set up with representatives of other provider groups to discuss these appointments.

Drs. J.M. Ingalls, Willard Scrivner, Joseph Skom, John J. Ring and David Rendleman were appointed to an ISMS Task Force concerned with the rules and regulations surrounding SHCC and the state planning agency.

### **Health Facilities Planning Rule**

ISMS was successful in temporarily blocking the adoption of Rule #9 by the Illinois Health Facilities Planning Board (IHFPB). The proposed rule—which ISMS believes discriminates against hospitals that are not affiliated with medical schools—would provide HSAs and the planning board with a means of evaluating applications for the acquisition of experimental or developmental equipment. ISMS offered its assistance to IHFPB in revising the rule.

### **Medical Audit Procedures**

The Board of Trustees will request the Illinois Foundation for Medical Care to formally investigate medical audit procedures of the Illinois Department of Public Aid and urge the IFMC to invite high volume Medicaid physicians to appear before it. Among the problems which IFMC will be asked to include in its study are: (1) due process for physicians; (2) confidentiality aspects of medical audits; and (3) retroactive application of the rules involving medical audit.

### **Unethical Physicians**

The Board directed that IDPA be asked to provide the Society with any evidence it may have regarding unethical conduct or questionable practices of physicians so that ISMS can take appropriate action. Should criminal charges be involved, IDPA will be requested to turn over the evidence to appropriate authorities.

In a related action, it was announced that the Governor has appointed the following to the Medical Disciplinary Board:

Drs. Willard Scrivner, Belleville; Helen Bonbrest, Chicago; Raimundo Rodrigues, Murphysboro; Levon Topouzian and James B. Williams, both of Chicago. An osteopath and chiropractor were also named. Dr. John Fultz, Jr., Chicago, is medical coordinator and chief enforcement officer of the disciplinary system.

### **Professional Liability Litigation**

On advise of legal counsel, the Board will not implement a House of Delegates resolution referred to it in April calling for: (1) panels of physicians to review all professional liability litigation; (2) publishing a monthly list of all patients and attorneys whom the panels adjudge to be involved in unreasonable, frivolous or malicious suits; and (3) informing all physicians that "any association he may have with such individuals exposes him to increased risk . . ." Legal counsel advised that implementation of the resolution could jeopardize the Society's status because: (1) ISMS could be sued for defamation of character; and (2) it may be in violation of federal and/or state law.

### **Dues Delinquent Members**

ISMS will send another letter informing dues delinquent members that the society's bylaws provide for them to be dropped from membership by June 30. Formal action regarding membership status will be deferred pending a report to the Executive Committee. The AMA portion of dues will be held until members have paid the ISMS special assessment.

### **Swine Flu Immunization**

Upon recommendation of its ad hoc Committee on Swine Flu Immunization, the Board of Trustees:

*(Continued on page 228)*



edema in acute inflammatory conditions and by causing soft-tissue swelling and bone damage associated with chronic inflammation. It exhibits analgesic activity in rodents by inhibiting the pain response in mice caused by the introduction of an irritant into the peritoneal cavity and by raising pain thresholds in edematous paws of rats. In rats made febrile by the subcutaneous administration of brewer's yeast, fenoprofen produces antipyretic action. These effects characteristic of nonsteroidal, anti-inflammatory, antipyretic, analgesic drugs.

**Indications and Usage:** Nalfon® (fenoprofen calcium, Dista) is indicated for relief of the signs and symptoms of rheumatoid arthritis. It is indicated in treatment of acute flares and in the long-term management of the disease. The safety and effectiveness of Nalfon have not been established in severe rheumatoid arthritis patients who are incapacitated by the American Rheumatism Association Functional Class IV. (Incapacitated, largely wholly bedridden, or confined to wheelchair, or no self-care.) Improvement in patients treated with Nalfon for rheumatoid arthritis has been demonstrated by a reduction in joint swelling, reduction in pain, a reduction in the duration of morning stiffness, a reduction in disease activity assessed by both the investigator and the patient, and by increased mobility as demonstrated by a reduction in the number of joints with limited motion.

In clinical studies in patients with rheumatoid arthritis, Nalfon has been shown to be comparable to aspirin in controlling the aforementioned measures of disease activity but the frequency of the latter gastrointestinal adverse effects (nausea, dyspepsia) and tinnitus was less than in aspirin-treated patients. It is not known whether Nalfon causes less peptic ulceration than aspirin.

In some patients Nalfon has been used in combination with gold salts or corticosteroids. Studies have been inadequate to demonstrate whether Nalfon adds any improvement in patients maintained on gold salts or corticosteroids. Whether Nalfon could be used in conjunction with partially effective doses of corticosteroid for a "steroid-sparing" effect has not been adequately studied. The use of Nalfon in combination with salicylates is not recommended because there is no evidence to demonstrate that Nalfon would produce any additional effect beyond that produced by aspirin alone. However, there is evidence that aspirin increases the rate of excretion of Nalfon.

There have been no studies in children; therefore, the safety and effectiveness of Nalfon in children are unknown.

**Contraindications:** Nalfon is contraindicated in patients who have shown hypersensitivity to it. Because the potential exists for cross sensitivity to aspirin and other nonsteroidal, anti-inflammatory drugs, Nalfon should not be given to patients in whom aspirin and other nonsteroidal, anti-inflammatory drugs induce the symptoms of asthma, rhinitis, or urticaria.

**Warnings:** Nalfon should be given under close supervision to patients with a history of upper gastrointestinal tract disease and only after consulting the "ADVERSE REACTIONS" section. Gastrointestinal bleeding, sometimes severe, has been reported in patients receiving Nalfon.

In patients with active peptic ulcer and active rheumatoid arthritis, attempts should be made to treat the arthritis with nonulcerogenic drugs, such as gold. If Nalfon must be given, the patient should be under close supervision for signs of ulcer perforation or severe gastrointestinal bleeding.

In subacute and chronic studies in rats, Nalfon caused interstitial nephritis, glomerulonephritis and renal papillary necrosis. These abnormalities were dose-related and began to appear at doses approximating the human dose. In chronic studies in monkeys interstitial nephritis also occurred following Nalfon administration. Although this was seen at doses considerably above the human dose, lower doses were not studied in this species. During the course of the clinical trials one patient developed renal failure and died with a diagnosis of septicemia, bilateral suppurative pyelonephritis

and renal papillary necrosis. It is not known whether these events were drug-related. A few patients developed mild elevations of the BUN during Nalfon® (fenoprofen calcium, Dista) therapy. Since Nalfon is eliminated primarily by the kidney, the drug should not be administered to patients with significantly impaired renal function. It is desirable to perform periodic renal function tests in all patients receiving Nalfon.

**Precautions:** In chronic studies in rats, high doses of Nalfon caused elevation of serum transaminase and hepatocellular hypertrophy. In clinical trials, some patients developed elevation of serum transaminase, LDH, and alkaline phosphatase which persisted for some months, and usually, but not always, declined despite continuation of the drug. The significance of this is unknown. It is recommended that periodic liver function tests be performed in patients receiving Nalfon and that the drug be discontinued if abnormalities occur.

The safety of this drug in pregnancy and lactation has not been established and its use during these events is, therefore, not recommended. Reproduction studies have been performed in rats and rabbits. When fenoprofen was given to rats during pregnancy and continued to the time of labor, parturition was prolonged. Similar results have been found with other nonsteroidal, anti-inflammatory drugs which inhibit prostaglandin synthetase.

In-vitro studies have shown that fenoprofen, because of its affinity for albumin, may displace from their binding sites other drugs which are also albumin bound and may lead to drug interaction. Theoretically, fenoprofen, as well as other nonsteroidal, anti-inflammatory agents, could likewise be displaced. Patients receiving hydantoin, sulfonamides, or sulfonylureas should be observed for signs of toxicity to these drugs. In patients receiving coumarin-type anticoagulants, the addition of Nalfon to therapy could prolong the prothrombin time. Patients receiving both drugs should be under careful observation.

In patients receiving concomitant Nalfon-steroid therapy, any reduction of steroid dose should be gradual to avoid the possible complications of sudden steroid withdrawal.

Patients with initial low hemoglobin values who are receiving long term Nalfon therapy should have a hemoglobin determination at reasonable intervals.

Peripheral edema has been observed in some patients taking Nalfon; therefore, Nalfon should be used with caution in patients with compromised cardiac function.

Studies to date have not shown changes in the eye attributed to Nalfon administration. However, because of adverse eye findings in animal studies with some other nonsteroidal anti-inflammatory drugs, it is recommended that ophthalmologic studies be carried out within a reasonable period of time after starting chronic Nalfon therapy and at periodic intervals thereafter.

Since food decreases Nalfon blood levels, the drug should be given 30 minutes before or two hours after meals during the daytime.

When phenobarbital, which may enhance the metabolism of Nalfon, is added or withdrawn, Nalfon dosage adjustment may be required.

Caution should be exercised by patients whose activities require alertness if they experience central nervous system side effects from Nalfon.

Since the safety of Nalfon in patients with impaired hearing loss has not been established, these patients should have periodic tests of auditory function when chronic Nalfon therapy is given.

Nalfon decreases platelet aggregation and prolongs bleeding time. Patients who may be adversely affected by prolongation of the bleeding time should be carefully observed when Nalfon is administered.

#### **Adverse Reactions: Digestive System**

The most common type of adverse reaction concerned the gastro-intestinal system. Dyspepsia occurred most frequently, being observed in about one out of seven patients. Other adverse reactions in descending order of frequency were: constipation, nausea, vomiting, abdominal pain, anorexia, occult blood in the stool, diarrhea, flatulence, and dry mouth.

Three instances of peptic ulceration and/or gastro-intestinal hemorrhage that may have been due to the drug and four instances in which drug relationship was questionable were observed in 3,391 individuals to whom the drug was administered for periods of time ranging up to 165 weeks.

In less than 2% of patients the drug was discontinued because of adverse gastro-intestinal reactions.

#### **Skin and Appendages**

The most common adverse effect was pruritus which was seen in about one out of ten patients. Other adverse reactions were: rash, increased sweating, and urticaria.

In about 1% of patients Nalfon® (fenoprofen calcium, Dista) was discontinued due to an adverse effect related to the skin.

#### **Nervous System**

The most frequent adverse reaction observed was somnolence which occurred in about one out of seven patients. Other adverse effects which occurred less frequently were: dizziness, tremor, confusion, and insomnia.

Nalfon was discontinued in less than 0.2% of patients because of these side effects.

#### **Special Senses**

The most common adverse reaction was tinnitus which was seen in about one out of ten patients. Other reactions observed in descending order of frequency were: blurred vision and decreased hearing.

In about 0.2% of patients Nalfon was discontinued due to adverse effects related to the special senses.

#### **Cardiovascular**

The most frequent adverse event observed was palpitations. This was noted in about one out of 25 patients. Tachycardia was observed less frequently.

In less than 0.5% of patients Nalfon was discontinued due to cardiovascular adverse reactions.

#### **Laboratory**

Anemia was noted in about one out of 500 patients. One patient required discontinuation of Nalfon therapy due to anemia. Increase in alkaline phosphatase, LDH, and SGOT were observed. ("See Precautions.")

#### **Miscellaneous**

Headache was seen in about one out of seven patients. Less frequently observed in descending order of frequency were: nervousness, asthenia, dyspnea, peripheral edema, fatigue, malaise, dysuria.

**Overdosage:** No specific information is available on the treatment of overdosage with Nalfon. If it should occur, standard procedures to evacuate gastric contents and to support vital functions should be employed. Since Nalfon is acidic and is excreted in the urine, it may be beneficial to administer alkali and induce diuresis. Furosemide (Lasix®) did not lower blood levels.

**Dosage and Administration:** For the initial treatment of rheumatoid arthritis, the recommended oral dose is 600 mg. four times a day. Although improvement may be seen in a few days in many patients, an additional two to three weeks may be required to gauge the full benefits of therapy. The dosage should be adjusted in accordance with the patient's condition and changes in disease activity. Daily dosage larger than 3200 mg. is not recommended. Nalfon should be administered 30 minutes before or at least two hours after meals. If gastro-intestinal complaints occur, administer Nalfon with meals or milk.

There have been no studies in children; therefore, the safety and effectiveness of Nalfon in children are unknown.

**How Supplied:** Pulvules Nalfon, 300 mg. (equivalent to fenoprofen), are supplied in bottles of 60 and 500 (No. 416). They are yellow and ochre in color. The Ident-Code® (formula identification code, Dista) symbol is H77.



600472

Additional information available to the profession on request.

**DISTA PRODUCTS COMPANY**  
Division of Eli Lilly and Company  
Indianapolis, Indiana 46206

## Obituaries

**Allaman, Loren E.**, Stronghurst, died in April of this year. Dr. Allaman was a graduate of Northwestern Medical School.

**Anker, Herbert S.**, Chicago, passed away at the age of 63 on May 18. Dr. Anker was a Professor of Biochemistry for 31 years at the University of Chicago.

**\*Dack, Gail M.**, Chicago, passed away June 21. Dr. Dack was a leading expert on food poisoning, he was a faculty member of the University of Chicago from 1925 to 1966, and an internationally known microbiologist. Dr. Dack was 75 at the time of his death in Elgin.

**\*El Bajadi, George E.**, Mt. Vernon, died July 4, at the age of 60. Dr. El Bajadi was an ophthalmologist.

**\*Ferguson, Edward V.**, Alton, died at the age of 60, May 18. He had been a practicing physician in Alton for 30 years. Dr. Ferguson was a graduate of Harvard Medical School.

**\*Frankel, Donald**, Chicago, 58. Dr. Frankel was a prominent Chicago allergist and President of the Flying Physicians Association. He was associated with Weiss Memorial Hospital in Chicago and St. James Hospital in Chicago Heights.

**Grey, Dorothy**, Evanston, died June 6 at the age of 85. Dr. Grey was the first woman intern at Evanston Hospital. She was a 1922 graduate of the University of Chicago Medical School and practiced 32 years in New York before retiring in Evanston.

**Grubb, Kenneth P.**, Evanston, died June 22. Dr. Grubb was on staff at Evanston Hospital for 20 years.

**\*\*Hantover, Matthew**, Arizona, formerly Bloomington, died July 17 at the age of 76.

**Hauber, Darwin K.**, Stronghurst, died May 1 at his home at the age of 61. Dr. Hauber had practiced optometry in Monmouth since July, 1946.

**Jenkins, Frank Lukenbill**, Chicago, died May 30, at the age of 79. He was a staff physician at Garfield Park Hospital for 40 years.

**Kooiker, Robert H.**, Jacksonville, died recently. He was Chief Pathologist at Passavant Area Hospital, Secretary of the Morgan-Scott County Medical Society and a member of the ISMS Medical Legal Council.

**Mason, Theodore Roosevelt**, Chicago, died May 1, at the age of 68. He was past director of the Riverside Sanitarium Hospital and founding and medical director of Friendship Clinic in Mound Bayou, Mississippi.

**Massey, George B., Jr.**, Winnetka, died June 24, in Boston, at the age of 68. Dr. Massey was very active in community affairs and the youth of the area.

**\*\*Mathre, Albert Ilmer**, Cambridge, died May 2, at the age of 84. Dr. Mathre was a former President of Henry County Medical Society.

**Pechous, Bohumil E.**, died in July. Dr. Pechous resided in North Miami, Florida, 9 months out of the year, but returned to Chicago in April, September and November to resume practice. Dr. Pechous was a hemopath. He graduated from St. Ignatius Medical School (now Loyola) and was class valedictorian.

**Robuck, Samuel Verner**, formerly of Chicago, died May 25, in Mesa, Arizona. Dr. Robuck, 90, was past president of the Illinois Association of Osteopathic Physicians and Surgeons.

**Smolic, Edmund A.**, St. Louis, Missouri, died at the age of 66 on July 10. He was a professor of Clinical Surgery, Section of Neurosurgery at the St. Louis School of Medicine and chairman of the Section of Neurosurgery at St. Johns Mercy Medical Center.

**\*Spicer, Donald D.**, Danville, died June 25, at Mercy Hospital, Aurora, at the age of 62. Dr. Spicer had practiced in Danville for 26 years. He was a past president of Vermilion County Medical Society and Medical Staff President of Lake View Memorial Hospital in 1966.

**Stericker, George Block**, Springfield, died at the age of 81 on June 17. Dr. Stericker was a 1927 graduate of Rush Medical College.

**\*Walker, William M.**, Chicago, died August 5. Dr. Walker was a noted Cancer Surgeon. He was 56 at the time of his death.

**Westgate, Clyde J.**, Lincolnwood, passed away July 21, at the age of 83. Dr. Westgate was an expert on roses and had served as a judge for the Chicago and Illinois Rose Societies.

**Witchurch, Anna Dean**, Chicago, died May 26 at the age of 84.

**Wich, Quintin J.**, Highland, died at the age of 46. Dr. Wick was on staff at the Veterans Administration Hospital in Poplar Bluffs, Missouri.

**Winden, Irwin**, Chicago, died July 13, at the age of 50. Dr. Winden was a professor of Special Education at Northeastern Illinois University for 12 years and past president of the World Education Fellowship.

*\*Indicates ISMS member*

*\*\*Indicates ISMS member of the Fifty Year Club*





# I M J

Illinois Medical Journal

Vol. 150, No. 3, September, 1976

## Impedance Audiometry in the Evaluation of Bell's Palsy

BY H. M. DEBARTOLO, JR., M.D., W. A. TURLEY, M.Ed., AND  
D. V. PIRNOT, M.Ed./PENNSYLVANIA

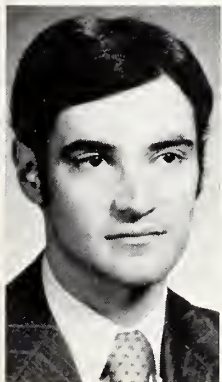
*The seventh cranial nerve, the facial, is affected by paralysis more often than any other nerve in the body. In patients with facial nerve paralysis, it is important to determine the site of lesion, since involvement of the nerve within its bony canal may require expedient surgical decompression. This report presents cases of Bell's palsy in which impedance audiometry was useful in the identification of the site of lesion. Impedance audiometry may help to localize the site of lesion in Bell's palsy when combined with other testing.*

### Case Report I

A 56 years old college professor with a 5 day history of unilateral facial paralysis presented to the Department of Otolaryngology at the Geisinger Medical Center.

Physical examination revealed loss of all movements on the right side of the face: voluntary, associated, and emotional. The affected side was immobile and expressionless. The labial fold was erased. The corner of the mouth sagged and the mouth was drawn toward the patient's sound

side, his left side. The wrinkles on the affected side of the forehead were smoothed out and the eyebrow was lowered. The palpebral fissure was widened. There was a Bell's phenomenon present on the right. Epiphora was present on the right as well as ectropion. The patient was unable to purse his lips. The right cheek puffed with respirations. When the glabella or supra-orbital ridge was tapped, the orbicularis oris muscle contracted less than the normal side. Schirmer test was performed and revealed a



HANSEL M. DE BARTOLO, JR., M.D.,  
At the time of writing, he was a student at the Stritch School of Medicine, Loyola University, Maywood. He served internship and residency training in General Surgery at the Maya Clinic, Rochester, Minn.



W. A. TURLEY, M.Ed. is a clinical audiologist at the Geisinger Medical Center in Pennsylvania.



D. V. Pirnot, M.Ed. is also a clinical audiologist at the Geisinger Medical Center, Pennsylvania.

response of 25 mm. after 1 minute in the right eye and 10 mm. after 1 minute in the left eye. Hilger nerve stimulation revealed all branches of the facial nerve stimulated at a setting of 3 milliamps on the right. This was comparable with the setting of 3 milliamps on the left. A red chorda sign was not observed. There was no reddening of the tympanic membranes. The remainder of the otolaryngology exam was within normal limits.

*Audiometric evaluation:* Pure tone testing revealed a bilateral high frequency sensorineural hearing loss. Speech reception thresholds of 6 dB. for the right ear and 8 dB. for the left ear were in good agreement with the two frequency pure tone averages. The patient's speech discrimination ability was excellent as evidenced by discrimination scores of 96% and 100% for the right and left ear respectively. These scores were obtained by presenting phonetically balanced word lists at an intensity level of 30 dB. above the speech reception thresholds.

*Impedance testing:* Tympanometry yielded normal middle ear curves bilaterally. Stapedial reflexes were obtained when the right ear was stimulated. Stapedial reflexes were absent when the left ear was stimulated.

Complement fixation studies were performed for herpes virus which showed no difference in acute and convalescent phase studies. Mastoid X-rays to show petrous pyramids were within normal limits.

The patient was treated with Methylcellulose eye drops, flannel eye patch, and tapering course of Prednisone, 30 mg. initial dose daily, tapered 5 mg. every 4 days. The patient was closely observed and was found to have 95% function return 6 weeks after initial visit.

### Case Report II

A 23 years old housewife presented to the Medical Center with a 3 week history of headaches and pain in the back of the neck. The day before she came to the clinic she noted that the left side of her face did not move.

Physical examination revealed a total left facial paralysis. Schirmer's test indicated normal and equal amounts of tearing bilaterally. Hilger nerve stimulation revealed normal conductivity which was equal bilaterally; in the upper branch 1.6 milliamps, lower branch 2 milliamps, and mid-face 3.5 milliamps. The remainder of the otolaryngology exam was normal.

*Audiometric evaluation:* Pure tone testing was within normal limits bilaterally. The speech reception thresholds of 2 dB. for the right ear

and 0 dB. for the left ear were in good agreement with the two frequency pure tone averages. Speech discrimination was 100% bilaterally at 30 dB. sensation level.

*Impedance testing:* Tympanometry revealed stiffness in the right middle ear and normal findings on the left. Stapedial reflexes were within normal limits bilaterally. Results of the physical examination and the above studies indicated the lesion was peripheral to the stapedial muscle innervation.

The patient was treated with Prednisone, 50 mg. three times daily for three days. Then, tapered doses of Prednisone were administered to the patient over a period of one week. One week after initial treatment, the patient had 80% function return.

### Case Report III

A 37 years old woman with a history of onset of left facial weakness about 5 to 6 weeks' duration presented to the Medical Center.

Physical examination revealed approximately 80% loss of function in the left side of her face. The patient was able to partly close her eye. Schirmer's test revealed greater than 25 mm. response after 5 minutes, bilaterally. There was no red chorda sign. The remainder of the otolaryngology exam was within normal limits.

*Impedance testing:* Tympanometry yielded stiffness curves bilaterally. Stapedial reflexes were obtained when the left ear was stimulated, but absent when the right ear was stimulated.

Clinical history and testing would indicate loss of facial nerve function between the geniculate ganglion and the stapedial nerve. She was started on Prednisone, 10 mg. q.i.d. Twelve days later, Bell's palsy was resolved and she was discharged.

### Discussion

Impedance audiometry measures the opposition of the ear to energy impinging on it. When sound enters the external auditory meatus, it travels until it reaches the tympanic membrane. Part of the energy striking the tympanic membrane causes that membrane to vibrate and ultimately stimulates the cochlea. This information is then carried to the brain. However, part of the energy of a sound wave which strikes the tympanic membrane is reflected back in the direction of the external auditory meatus. If the external auditory meatus is closed with an air tight seal, reflected sound waves can be measured and yield information concerning the middle ear. When a normal ear receives a pure



tone 70 to 90 dB. above absolute threshold of audibility from 250 Hz. through 4000 Hz., a bilateral contraction of the stapedius muscle will take place.

The stapedius muscle occupies a small area in the pyramidal eminence on the posterior wall of the middle ear space. The tendon of the stapedius muscle passes through a small opening at the top of the pyramidal eminence, turns downward, travels anteriorly and is attached to the posterior margin of the neck of the stapes.

When the stapedius muscle contracts, the posterior crus of the stapes is pulled backward and inward. At the same time, the anterior crus of the stapes rolls laterally. These motions cause an outward movement of the tympanic membrane. Evidence of contraction of the stapedius muscle is easily identified in the impedance audiometry with the use of an electroacoustic impedance bridge.

The electroacoustic impedance bridge consists of a probe which is sealed air tight in the external auditory meatus by means of small plastic tips of varying sizes. Three tubes are housed by the probe: an air supply, microphone, and receiver. The receiver delivers a probe tone of 220 Hz. The probe is held in place by a headband. The other side of the headband holds an earphone which is connected to an audiometer. (Fig. 1)



Figure 1. Electroacoustic Impedance Bridge.

Intensity changes of the probe tone obtained with varying air pressure in the ear canal are measured directly from the balance meter located on the body of the electroacoustic impedance bridge. Two scales on the bridge allow for direct reading in cc in compliance on the lower scale, or impedance measured in acoustic ohms as read from the upper scale.

Using impedance audiometry to test the stapedial reflex, combined with other testing, it is possible to test the branches of the seventh nerve

and identify the site of lesion in facial nerve paralysis.<sup>1-5</sup> The branches of the seventh nerve are responsible for homolateral lacrimation, the stapedial reflex, homolateral submaxillary salivary gland secretion and taste function from the homolateral anterior two-thirds of the tongue. (Fig. 2)

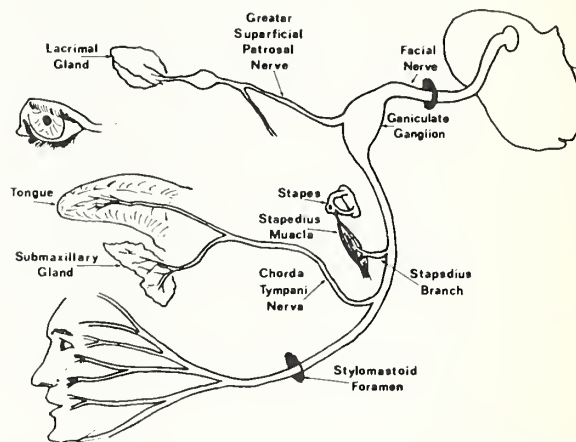


Figure 2. Branches of the Seventh Nerve (adapted from Alford 1).

If a positive stapedial reflex is elicited on the paralyzed side, the site of lesion is distal to the stapedial muscle innervation. If taste to the homolateral anterior two-thirds of the tongue is absent and a stapedial reflex is obtained, the site of lesion is distal to the stapedial nerve. The lesion is distal to the stapedial branch when taste is lost but a reflex is present. If tearing function is present but the stapedius reflex is absent, the lesion is between the geniculate ganglion and the stapedial branch. If tearing function is lost and the stapedius reflex is absent, the lesion is proximal to the geniculate ganglion.

If, by way of these studies, a lesion is demonstrated peripheral to the narrow bony canal of the facial nerve, urgent surgical intervention may be avoided with good result. Impedance audiometry may help to localize the site of lesion in Bell's palsy when combined with other testing.

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# The Vicissitudes of Psychogenic Pain

BY V. SIOMOPOULOS, M.D. AND NANCY WILLIAMS/CHICAGO

*Physical pain is a subjective experience which arises when there is tissue damage of any degree. In the specific case of damage concerning nerve tissue, the term "neurogenic" pain is used to denote the origin of pain. This is the case, for example, of the various causalgias. Persons experiencing physical pain usually communicate their sensation of pain verbally, but also through bodily signs, postures and facial expressions.*

*There are cases, however, when an individual communicates an experience of pain, although there is no evidence of tissue damage to account for this pain. This type of pain is known as psychogenic pain. The term denotes that the origin of the pain is not in the body, but in the "psyche," or the mind of the individual, although it is rather difficult to understand how this may happen. The non-psychiatric physician would variously, and at times interchangeably, describe this type of pain as "psychosomatic," "hysterical," or "hypochondriacal" pain. However if he makes an attempt to understand the problem, generally he remains puzzled: "How could this happen? Does the patient really experience pain?"*

It should be noted from the outset that in this case the use of the term "psychosomatic pain" is an unfortunate one, misleading and confusing. The confusion may arise from the fact that there is a group of diseases called "psychosomatic diseases," whose origin is attributed to emotional conflicts, but they are, nevertheless, physical illnesses causing tissue damage and physical pain, not psychogenic pain. If one is to use the term "psychosomatic pain" as a synonym for psychogenic pain, he should be clear that there is no connection, whatsoever, between the pain he describes and any psychosomatic illness.

If it is true, as some informal statistics state, that psychogenic pain and various "psychosomatic" ailments constitute the 70% of the practice of the general physician, questions about the nature of psychogenic pain are not just philosophical, but of great practical interest. Certainly, the general physician should like to know exactly what he is treating. Questions of differential diagnosis and treatment of the vari-

ous psychogenic pains are of equal, if not of greater importance.

The interrelationship between mental and bodily processes still remains obscure and largely unexplored. As a result, questions about the origin as well as the differential diagnosis and treatment of psychogenic pain become meaningful, if one focuses, as we do in this article, not on the mysterious "leap" from the mind to the body, but on what may be regarded as the purely symbolic and communicative aspects of psychogenic pain.

## Hysterical Pain

**Case Report:** A 16-year-old girl complained of pain on the left side of her chest. Her description of the pain was vague and atypical. The pain had been constant for several weeks. It did not radiate and its intensity was non-descript. Physical examination, EKG, and all relevant laboratory findings failed to reveal the presence of any physical illness. Because she also complained of insomnia, tension and difficulties in keeping up with her school work, she was referred for a psychiatric evaluation which she accepted with great reluctance. A careful psychiatric interview revealed that a few days before the onset of the chest pain, she had broken up with her boy friend, an affair she had kept secret from her parents.

## Comment

The patient's chest pain makes sense if we look at it in the context of her relationship with her boy friend. The break-up of the relationship ap-



V. SIOMOPOULOS, M.D., is Assistant Clinical Professor in the Department of Psychiatry at the University of Illinois and staff psychiatrist at the Illinois State Psychiatric Institute. He is also on the courtesy staff of Ravenswood Hospital and a consultant in the Guidance Clinic of St. Francis Hospital, Evanston.

NANCY SUE WILLIAMS is a junior medical student at the University of Illinois. She graduated from Eastern Illinois University, Charleston.



parently left our patient with a "broken heart." "Broken heart" is, of course, a symbolic expression which denotes that the patient's feelings were hurt. To understand the nature of her pain, we should remember that besides the three types of pain already mentioned, physical, neurogenic, and psychogenic pain, which are experienced always in reference to various parts of the body, there is another type of pain, psychic pain, which is experienced purely as a mental event with no bodily referents. "Psychic pain" is a term of higher abstraction than any of the other three terms, since it refers to affective states, such as depression, humiliation, shame, guilt, and other similar feelings—experiences associated not with concrete bodily changes, but with interpersonal events, interactions with other people which damage not the body, but one's psychic structure, the set of values, ideals and goals cherished by this person.

Our patient obviously experienced psychic pain in response to the break-up of the relationship with her boy friend. However, she communicated her pain in a symbolic way, typical of the type of pain we call hysterical. When she said she had chest pain she was obviously switching from the frame of reference of psychic pain to the frame of reference of physical pain. This switching became possible by virtue of the cultural belief, promulgated from generation to generation, that the heart regulates human feelings. Undoubtedly, the switching is reinforced by the stronger communicative power of bodily pain. Bodily pain impresses upon us much stronger than psychic pain. It is clear that when our patient stated that she experienced pain, she did experience pain, which, however, was not located in the chest. She was actually communicating psychic pain, emotional suffering. Yet, one should not be left with the impression that she was lying when she complained of chest pain. She was totally unaware of the shift in the frames of reference she was making—she was suffering from a "broken heart."

### Hysterical Voices

We see the same process in hysterical patients who talk about hearing "voices."<sup>1</sup> In contrast to schizophrenic patients who give vivid verbatim accounts of their auditory hallucinations, these patients describe their "voices" vaguely, make contradictory statements, and look embarrassed when they are asked to reproduce the exact wording of their "voices." Actually, they are communicating thought contents, which they

label "voices," not perceptual auditory occurrences. These patients are making a linguistic shift from the frame of reference of thought content to that of sensory experience. This shifting is dynamically determined, like the case of hysterical pain, by a number of conscious or unconscious motivations, among which the wish to assume temporarily the dependent role of a sick person seems to play a dominant role.

An analogy may be drawn between the hysterical patient and the little child who, quite seriously, tells his friends that he has an airplane at home. Actually, he has a toy airplane, but, in order to impress his friends, he switches from the frame of reference of toys to the frame of reference of real things. Certainly, he was not lying, since in his fantasy life the toy airplane serves all the uses and purposes of a real airplane.

Our patient represented a typical case of hysterical pain. The symbolic and communicative aspects of it were quite transparent. In other cases of hysterical pain, the role of bodily organs as psychological objects loaded with personal and cultural meaning may not be so apparent. Localization of physical pain is a neuro-physiological process carried out by the respective cortical centers that receive afferent fibers of pain. Localization of hysterical pain is a psychological process carried out by the patient's repertoire of personal and cultural meanings in reference to various body parts and organs which become vehicles of expression of psychic pain.

### Hypochondriacal Pain

**Case Report:** A 50-year-old widowed woman complained of headaches, backaches, stomachaches, pain in the joints and problems with her "female organs" of several years duration. She spoke rapidly and anxiously, and expressed fears that she had ulcers of the stomach, arthritis, and cancer of the uterus. She had taken numerous analgesics, tranquilizers and other medications, changing from one to another, but with no avail. Thorough physical examination and laboratory work-up revealed no organic basis for her pains, but this did not dissipate her fears.

### Comment

Here we are dealing with the type of psychogenic pain commonly known as hypochondriacal pain. Unlike hysterical pain, hypochondriacal pain has no symbolic meaning attached to it.

Also in contrast to hysterical pain, which at a given time is strictly localized by virtue of the symbolic meaning associated with the "suffering" body part or organ, hypochondriacal pain may refer to a single body part, but usually refers to many body parts.

Most authors<sup>2</sup> agree that hypochondriacal pains and complaints do not constitute a separate clinical entity, but they are symptoms of other mental illnesses, such as various neuroses, schizophrenia, and psychotic depression. However, the second edition of the Diagnostic and Statistical Manual of the American Psychiatric Association<sup>3</sup> does distinguish a separate hypochondriacal illness classified as "hypochondriacal neurosis." In a case like the one described above, in which the hypochondriacal pain is accompanied by fears of various illnesses, fears which do not carry any degree of conviction, the use of the term "hypochondriacal neurosis" is most appropriate.

However, there are cases in which the hypochondriacal pain is accompanied not by fears, but by all sorts of delusional—false and incorrigible—beliefs about the function of various parts of the body. Other delusions, such as delusions of persecution and grandeur as well as auditory hallucinations may be present. To describe such cases, which display typical symptoms of psychosis, as "hypochondriacal neurosis" would be grossly inaccurate. In other cases, hypochondriacal pain, most often localized, may be accompanied by the delusional belief that the underlying organ has been destroyed, or is suffering from an incurable disease. Profound depression, ideas of hopelessness and helplessness and suicidal ideas are usually present in such cases which should be correctly diagnosed as psychotic depression. Indeed, hypochondriacal pain may be present in a broad spectrum of psychiatric illnesses.

### Discussion

Undoubtedly, hypochondriacal pain, being a form of psychogenic pain, expresses mental rather than physical suffering. The patient with neurotic hypochondriacal pain represses a multitude of conflictual experiences, which may have to do with his need for physical intimacy, loneliness, doubts and concerns about his inner resources, and displaces their affect into concerns about his physical health. Now, he is not concerned about the painful realities that surround him, but instead he is totally absorbed into the "aching" of his body, his little universe of suffering. Minor,

trivial physical discomfort is built up out of proportion and becomes the source of tremendous anxiety concerning the patient's physical health.

On the other hand, the schizophrenic patient with hypochondriacal pain attempts to deny and project the nature of his suffering: "It's not my mind that is sick; it's my body." To support the belief that his body is sick, he would anxiously look for minor discomforts, changes and distortions in various parts of his body, which he perceives and interprets in a delusional manner.

In contrast, the psychotic depressed patient with hypochondriacal pain does not deny his depression and general emotional suffering. Rather he expands it to include bodily suffering: "It's not only my mind that suffers, my body suffers, too." Unlike the schizophrenic patient who attempts to confirm the premise that there is something wrong with his body, the psychotic depressed patient builds up small discomforts out of proportion because of his general attitude toward himself. He perceives himself as a totally worthless person. He is guilt-ridden and thinks he deserves punishment for his misdeeds. The bodily aches naturally complete the picture. At times, the bodily aspects so dominate the behavior of this type of patient that the whole process becomes reversed to the extent that the patient now blames his hypochondriacal illness as the cause of all his depression and emotional suffering.

### Psychogenic Pain as a Depressive Equivalent

**Case Report:** A 62-year-old divorced man requested psychiatric help, because of early morning awakening accompanied by "fearful anxiety," which he attributed to "frustrations and boredom" with his life situation. He also complained of a chronic pain in his anal, rectal and genital areas. He described the pain in great detail: It started in the anal and rectal area and radiated bilaterally through the pelvis into the penis, where it produced "intense discomfort" and a feeling of "increasing pressure" alleviated by urination. This all began 24 years ago when, because of the absence of sexual relations in his marriage, he visited and had sexual intercourse with a prostitute. Soon after the appearance of the pain, he had consulted several physicians, who upon physical examination could not find a physical basis for his pain. There was a physician who recommended and performed on him a "prostate operation," but the pain was not relieved. Three years later another physician thought that a vasectomy might relieve the feel-



ing of pressure inside the penis. This was done, but with no avail. The pain continued throughout the intervening 20 years.

An inquiry into the patient's life history revealed numerous traumatic experiences throughout his life—loss, physical abuse, rejection, frustration. His mother had died during a flu epidemic when he was 8 years old. Six months later his two older brothers had died of scarlet fever and diphtheria. Shortly thereafter the patient's father was remarried, but the new stepmother physically abused the child for running away from home. So at the age of 16 he left home permanently. Eight years later he was married but his marriage turned out to be a failure. His wife was cold, unemotional, and refused to have sexual relations with him. However, she had had a number of extramarital affairs. This depressed patient felt terribly lonely, as if, as he put it, the world was going on around him, while he was "sitting still and uninvolved." Nine years after marrying he had a "nervous breakdown" with depression, insomnia, palpitations, frequent sweating, and occasional suicidal thoughts. At this time he was hospitalized briefly as a psychiatric patient, followed by outpatient psychiatric treatment. Two years later the anal-rectal-genital pain began.

### Comment

Obviously, our patient suffered from chronic psychogenic pain. There were no accompanying fears or preoccupations with his physical health, nor evidence of psychosis, nor apparent clinical depression, although there were signs suggestive of it. Many authors have observed that at times severe depression may be masked by various chronic "hypochondriacal" and "psychosomatic" complaints. Lesse,<sup>4</sup> in a study of 336 patients with masked depression of various organ systems (central and peripheral nervous system, cardiovascular, respiratory, gastrointestinal, genitourinary, otolaryngologic, osseous, joint, and dental), found an astounding element of chronicity in over half of his patients, with the age distribution reaching its peak in middle age. Of these patients, 32% had been "ill" for more than five years, 15% for more than 10 years, and 5% for 15 or more years. The onset of these complaints was associated with various environmental traumas related to vocational and social situations, sexual problems, physical illness, economic pressures, and menopausal changes.

In the vast majority of cases, according to this study, the underlying depression is not diagnosed and the patients are subjected to a variety of

treatment procedures, some quite radical. The diagnostic difficulty arises because this is *depression sine depression*, i.e., there is no apparent clinical depression, although in some cases probing by an experienced interviewer may reveal a sense of meaninglessness and boredom with occasional ideas of hopelessness and helplessness. In time, however, the depressive core rises to the surface and becomes a full blown depression or a suicidal attempt.

The nature of the "bodily" pain in such cases is rather obscure. It is reasonable to assume that it expresses chronic psychic suffering. However, cultural overtures may also be present. In our patient the well known slang expression, used to describe psychic discomfort of an interpersonal nature as pain in the anal-rectal area, loses its metaphorical meaning to become literal pain in this particular area.

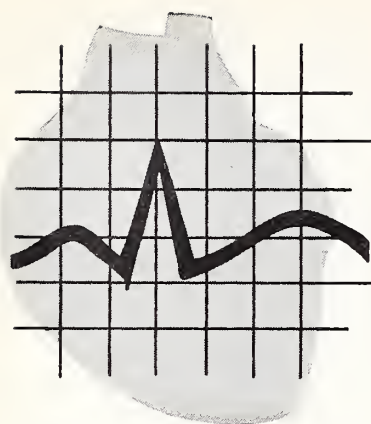
### Treatment Considerations

Whenever a patient complains of pain in one part of his body or another, the physician should do an appropriate medical work-up to rule out the presence of physical illness. Even when the character of the pain (anatomic location, duration, radiation, fluctuation, intensity) is quite atypical and by all clinical evidence psychogenic, true organic lesions may be concomitantly present and account in some instances for some of the manifest symptoms and signs. Lesse<sup>4</sup> found that slightly more than one-third of his 336 patients with masked depression had co-existent organic lesions, which were responsible for a small part of the clinical syndrome.

Hysterical pain is usually transient. The patient needs support, reassurance and a positive accepting attitude from the physician. Interpretation of the meaning of the "bodily" pain may or may not be necessary, depending on the patient's level of sophistication and willingness to talk in psychological terms. A positive physician-patient relationship will heal the wounds of a broken meaningful relationship in the patient's life without any awareness on the part of the patient about the symbolic meaning of his pain.

Hypochondriacal pain poses questions differential diagnosis of the underlying psychiatric illness: "Is it neurosis, psychotic depression, or schizophrenia?" Patients with hypochondriacal symptoms of psychotic depression—profound depression, insomnia, loss of weight, guilt, delusional hopelessness and helplessness—represent serious suicidal risk and should be hospital-

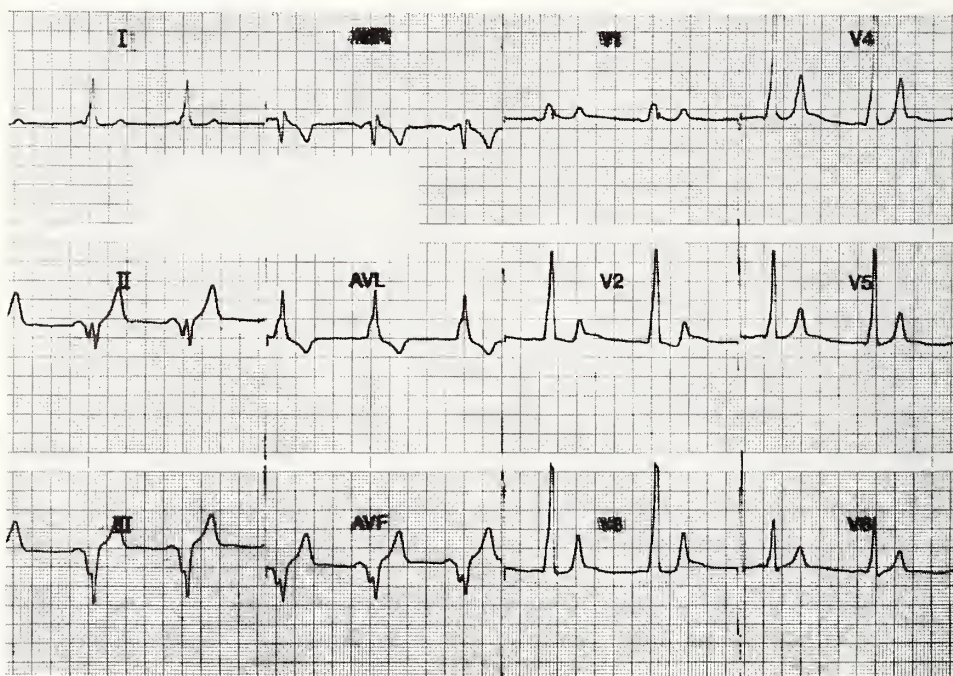
(Continued on page 217)



## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

A forty-eight year old man entered the emergency room after vomiting blood twice during the last three hours. He gave a history of intermittent epigastric pain for nine months that occasionally radiated straight through to his back and was regularly waking him from sleep. He had been controlling the symptoms to some degree with antacids and milk. Subsequent nasogastric suction demonstrated much blood from the stomach. Since surgery for a bleeding ulcer was a possibility, this ECG was obtained.



### Questions:

#### 1. The ECG shows:

- A. Inferior-true posterior wall myocardial infarction.
- B. Left axis deviation.
- C. Left ventricular hypertrophy.
- D. Wolff-Parkinson-White syndrome.
- E. Complete left bundle branch block.

#### 2. Treatment should include:

- A. Cancellation of all thoughts of surgery.
- B. Admission to the coronary care unit.
- C. Digitalis.
- D. Procainamide prophylaxis.
- E. None of the above.

*(Answers on page 244)*



# Adult Surgical Treatment of Female Pseudohermaphroditism

BY RICHARD L. SPERLING, M.D., F.A.C.P.; MANUTCHEH SOHAAY, M.D.; AND  
JAY J. GOLD, M.D., F.A.C.P./CHICAGO

*Sex change in early childhood for children assigned the wrong gender is a well established procedure. The surgical correction of female pseudohermaphroditism at an unusually late age is discussed together with the etiology of this uncommon syndrome.*

Children who have had the wrong sex assigned to them in infancy present a considerable problem. This mistake is often made in females with adrenal hyperplasia with masculine external genitalia. Conversely, males with severe degree of hypospadias may be reared as females.

Following the work of Money, Hampson, et al,<sup>1-3</sup> it is generally considered too emotionally traumatic to change the rearing sex after 18 months of age. They indicated that the gender role is so well established in most children by the age of 2½ years that it is too late to make a sex change with impunity. Wilkins<sup>4</sup> stated that a change in sex after the age of 1½ to two years, except in rare instances, invariably led to confusion and psychological disaster. On the other

hand, Dewhurst, et al,<sup>5</sup> with due reference to the work of Money, pointed out in their review of 20 cases that 15 cases did very well after the initial surgical, hormonal, and psychiatric treatment with the change of sex over the age of three years. This was supported by Janberg et al<sup>6</sup> and Norris et al<sup>7</sup> who reported the successful change of sex at puberty. The following case supports the views of the latter authors since the change in sex was made at age 21.

## Case Report

This patient was a 21-year-old white male who was referred to the endocrinologist (J.J.G.) due to confusion as to his true sex. He was the second of two children and noted to have a very small penis and bilateral cryptorchidism at birth. At three years of age he was hospitalized for acute abdominal pain and laparotomy disclosed mesenteric lymphadenitis. At that time, he was described as looking older and larger than his stated age and was noted to have pubic hair. He apparently received some injections at that time that may have been testosterone or human chorionic gonadotropins. His rapid growth continued until 12 years of age when he reached 60 inches in height. Gynecomastia was noted at the age of six years as which time his voice also deepened. In the past few years, he has noted increase in facial hair, and he shaves every three days. He sought medical advice because of his confusion relating to his sexual status and because he could not completely identify as a male although he was able to attend college and function without difficulty.

Physical examination revealed a short patient who was externally masculine in appearance. Measurements were 60 inches in height; arm span of 59½ inches; pubic-to-floor measurement 29½ inches; and weight of 110 pounds.

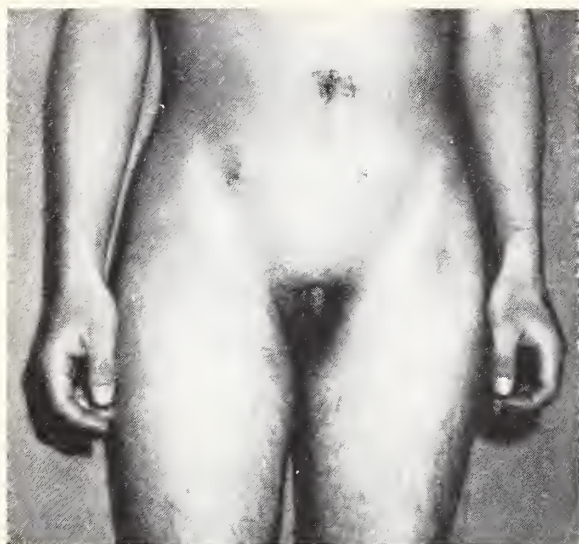


RICHARD L. SPERLING, M.D., F.A.C.S., is clinical associate professor of surgery (plastic) at Loyala University, Stritch School of Medicine and Chief of Plastic Surgery Section at St. Francis Hospital, Evanston. He is also on the Attending Staff of Skokie Valley and Lutheran General Hospitals and maintains a private practice in plastic and reconstructive surgery. As well, Dr. Sperling is a lecturer in surgery and ophthalmology at the University of Illinois Abraham Lincoln School of Medicine, and a plastic surgical consultant to the University of Illinois Center for Craniofacial Anomalies.



MANUTCHEN SOHAAY, M.D., is clinical assistant professor of surgery (plastic) at Loyala University, Stritch School of Medicine and attending staff at Cook County Hospital and West Suburban Hospital, Oak Park.

JAY J. GOLD, M.D., F.A.C.P., is clinical professor of medicine at the University of Illinois Abraham Lincoln School of Medicine and Chief of Endocrinology Section at St. Francis Hospital, Evanston. He is also a consultant in medicine and endocrinology at West Side V.A. Hospital.



Figures 1a and 1b. Preoperative A-P and lateral views of patient.



Figure 2. Preoperative view of external genitalia.

There was bilateral breast tissue with immature nipples and areolae. There was a bound down "penis" which was small (large for a clitoris) with hypospadias. The labioscrotal folds were fused with no gonadal tissue in them or in the inguinal area. Rectal examination revealed no prostate, but the area was sharply angled at that point and might represent a blind vaginal pouch.

### Evaluation

The patient was admitted to St. Francis Hospital in Evanston, Illinois for a complete evaluation. Chromosome studies showed a normal female chromosome complement; gonadotropins were less than 5 muu/24 hours (N is 5-50 muu/24 hours); growth hormone was 29 ng/ml (N in male is 0-8 ng/ml and in female is 0-30 ng/ml); 24 hour urine estrogens was 0.44 ug/24 hours (N in male is 4-25 ug/24 hours and in female is 5-100 ug/24 hours); serum testosterone was 188 ng% (N in male is 400-1200 ng% and in female is 30-150 ng%); 24 hour urine pregnandiol was 0.7 mg/24 hours (N is 0.5-7 mg/24 hours); 17 OH steroids was 3.5 mg/24 hours (N is 2-10 mg/24 hours); 17 Ketosteroids was 8.8 mg/24 hours (N in male is 10-20 mg/24 hours and in female is 5-15 mg/24 hours); Plasma cortisol was 28.8 mcg% (N is 7-27 mcg%).

An intravenous pyelogram and voiding cystourethrogram were performed which revealed normal bilateral renal function with a normal appearing upper collecting system. Contrast material was allowed to flow through an indwelling catheter and filled a large lumen which initially was thought to represent the urinary bladder but later was believed to be the vagina since, as more contrast material was administered, there was a



structure filled which was superior to this lumen and thus interpreted as a uterus.

In April, a laparoscopy was performed at which time the ovaries were noted to be present bilaterally as well as fallopian tubes and uterus. Ovarian biopsies revealed the presence of primordial follicles. The patient was advised of the findings and referred for psychiatric counselling.

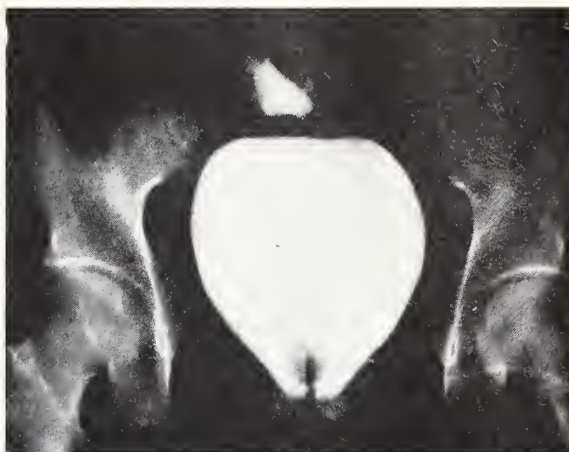
### Psychiatric Counselling

During the course of psychiatric counselling, the patient was made aware of the many problems that would have to be faced. When it was felt that he had developed sufficient insight, it was suggested that he try the role of a female by dressing and acting the part before any surgical changes were made. This entailed shopping for female clothing and then wearing them, etc. This was a difficult transition for the patient, but the patient adjusted and was thought to be ready for the next phase.

### Surgical Procedure

By December, the patient was readmitted to St. Francis Hospital at his request for reconstruction of female external genitalia. Patient was taken to surgery by a team composed of a plastic surgeon (R.L.S.), gynecologist, and urologist. The patient first underwent cystoscopy since it was believed that the patient had a urogenital sinus. A line of incision was marked around the lower portion of the clitoris to the midline, and it was directed down to about one inch above the anus. A large tube-shaped structure was identified which was believed to be the vagina. The previously inserted Foley catheter was inside this tube. The tube was opened, and it was then identified as a very dilated urethra.

Approximately two centimeters further there was another opening at the posterior part of the urethra which was the opening of the vagina. The vagina was separated and brought out and sutured to the lower portion of the skin of the wound with 3-0 chromic. The urethra was then constructed over the Foley. The remainder of the urogenital opening was sutured to the edge of the skin except at the upper part where the clitoris was amputated and buried below the skin. The patient had a satisfactory postoperative course and was discharged from the hospital five days later. She was placed on Premarin 0.625 mg. daily.



Figures 3a and 3b. Voiding cysto-urethrogram in A-P and lateral views.

### Post-operative Course

Although a small uterus is present, the patient has shown no evidence of withdrawal bleeding on estrogen therapy with added intermittent progestin. She continued to attempt to adjust to her new life but found many frustrations including feelings toward sexual intercourse. She developed suicidal thoughts and depression and arranged to have herself admitted for psychiatric help. During the course of this hospitalization, she gained new insight and became more self assured in her new role.



Figure 4. Postoperative view of external genitalia.

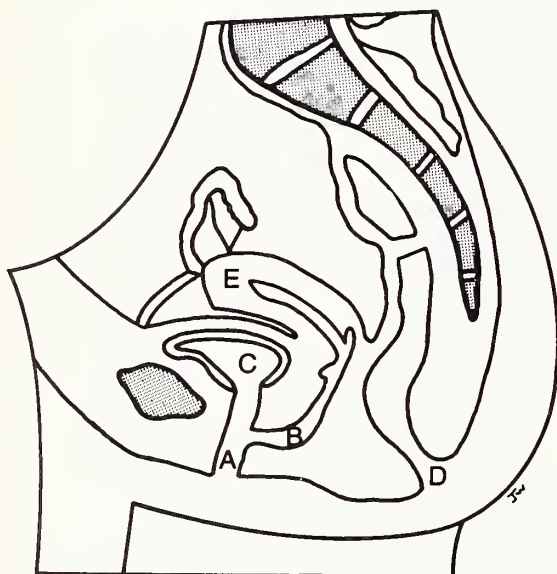


Figure 5. Diagram of preoperative anatomy of patient's pelvis, A=dilated urethra; B=vagina coming off dilated urethra; C=bladder; D=rectum; E=uterus.

The patient subsequently met a male patient, and their mutual professed love led to coital

relationships on two occasions. She reported that the first experience was physically and emotionally trying, but she experienced no difficulty subsequently.

### Discussion

Aphrodite in a celestial union with Hermes brought forth an extraordinary child which had female as well as male features. Unable to determine its sex, they gave the child both their names. Hermaphroditos.<sup>8</sup>

If an individual has both sex organs, it is a true hermaphrodite. If an individual has organs of one sex but external genitalia more characteristic of the other sex, it is a pseudohermaphrodite. If in a pseudohermaphrodite the gonad is a testis, the individual is a male pseudohermaphrodite; if the gonad is an ovary, the individual is a female pseudohermaphrodite.

### Congenital Adrenal Hyperplasia

In female pseudohermaphroditism, several possibilities exist.<sup>9</sup> The first is congenital adrenal hyperplasia or virilizing tumor, either ovarian or adrenal. Although as early as 1866, Credidio<sup>10</sup> described the history of an individual, Joseph Marzo, who lived as a man but whose autopsy revealed adrenals as large as kidneys with atrophic Müllerian derivatives and a vagina opening into the urethra. It has only been recently that female pseudohermaphroditism due to adrenal cortical hyperplasia has been well recognized.

Wilkins<sup>11</sup> classified the syndrome occurring in genetic females and characterized by the virilization with hirsutism, an enlarged clitoris, malformations of the external genitalia, skin pigmentation, and short stature due to premature epiphyseal closure. The characteristic laboratory finding of elevated urinary 17-Ketosteroids is necessary for one to make the diagnosis. Elevated urinary pregnanetriol is also found and may be the specific metabolite characteristic of the disease. The syndrome is sometimes associated with abnormal electrolyte metabolism, hypertension, and other disturbances. If untreated, menstruation will never occur while maturation of secondary sex organs does. When properly treated with cortisone, virilization is arrested and menstruation with ovulation occurs.

Adrenogenital syndrome due to adrenal cortical hyperplasia is secondary to a heritable in-born error of metabolism.<sup>12</sup> The incidence suggests that an autosomal recessive genetic factor is responsible. The basic defect is a congenital partial or complete absence of one or several



adrenal enzymes necessary for cortisol production with accumulation of androgenic steroidal precursors. The adrenal hyperplasia is secondary to increased ACTH production by the pituitary because of deficient cortisol production disrupting the adrenal-hypothalamic-pituitary feedback mechanism. The virilization is due to the overproduction of adrenal androgens. Adrenal hyperplasia can be distinguished from adrenal tumor by the fact that administration of cortisone causes a marked decrease in the output of 17-Ketosteroids in cases of hyperplasia but not with tumor.

### Use of Androgens in Pregnancy

The second possibility for pseudohermaphroditism is pregnant females treated with androgens or progesterone in an attempt to avert habitual abortion. The age of the fetus is a critical factor in the response of the sex primordia to androgens since the capacity to stimulate external genitalia, urogenital sinus, and Wolffian ducts is limited to a specific period of time. Prader<sup>13,14</sup> has divided the different degrees of masculinization of urogenital sinus into five types dependent upon when the androgen is administered.

**Type 1** *Androgen Effects after 20 Weeks of Fetal Life*  
The vulva has been formed and only clitoral hypertrophy results.

**Type 2** *Androgen Effects after 19 Weeks of Fetal Life*  
The vulva gapes but is funnel-shaped and the clitoris is enlarged. The vagina and urethra open separately.

**Type 3** *Androgen Effects at 14 to 15 Weeks of Fetal Life*  
The vagina and urethra open into a common urogenital sinus. The clitoris is larger and penis-like.

**Type 4** *Androgen Effects at 12 to 13 Weeks of Fetal Life*  
The perineum is thrust forward, the narrow urogenital sinus is formed, and the labia form a bifid scrotum. The urogenital sinus opens at the base of the penis corresponding to a hypospadiac penis.

**Type 5** *Androgen Effects at 11 Weeks of Fetal Life*  
The external genitalia have a male appearance except for the absence of testes in the scrotum.

In female pseudohermaphrodites without adrenal hyperplasia, the diagnosis is usually made by exclusion. Certainly all pregnant females receiving hormones do not produce masculinized offspring. The difference in placental permeability to hormone, organ sensitivities, and hormonal metabolism seem to predict which offspring will be affected. The degree of involvement is related to the dosage and period of pregnancy.

### A Third Cause

The third possibility for pseudohermaphroditism is clitoral enlargement caused by soft tissue growth such as hemangioendothelioma, lipoma, or neurofibromatosis.

This patient had female pseudohermaphroditism but without apparent adrenal hyperplasia. The 17-Ketosteroids were normal. Nothing is known of the patient's mother or her pregnancy, so that definitive statements of cause and effect cannot be made. It is likely that an androgenic stimulus occurred early in the gestation to create the anatomic changes seen in this patient. Therapy has been surgical in an attempt to establish a normal pelvic status for function, followed by hormonal therapy to induce menstrual periods. Theoretically, her own ovaries should be able to take over; however, as noted earlier, injections were given at a very early age that may have caused ovarian and hypothalamic changes that would prevent subsequent normal ovarian function. ◀

### References

A list of references for "Adult Surgical Treatment of Female Pseudohermaphroditism" may be obtained by writing IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

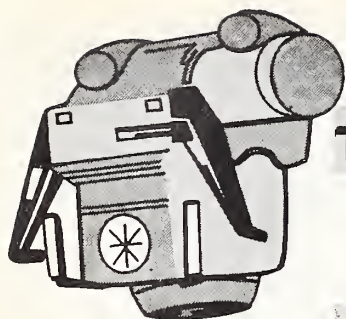
### Psychogenic Pain

(Continued from page 211)

ized. The diagnosis of schizophrenia in a patient with hypochondriacal complaints, when not apparent by the general disorganization of the patient's personality, may require careful probing by an experienced interviewer to uncover possible delusional beliefs attached to hypochondriacal pain, or even unrelated to it. Such cases should certainly be referred for psychiatric evaluation and treatment. However, patients with hypochondriacal complaints masking an underlying depression could be treated by the general practitioner on an outpatient basis with supportive psychotherapy and adequate amounts of tricyclic antidepressants (Tofranil, Elavil). ◀

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## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

A 40-year-old female who had had a cholecystectomy and common duct exploration six days ago developed a high temperature and abdominal pain.  
What's your diagnosis?

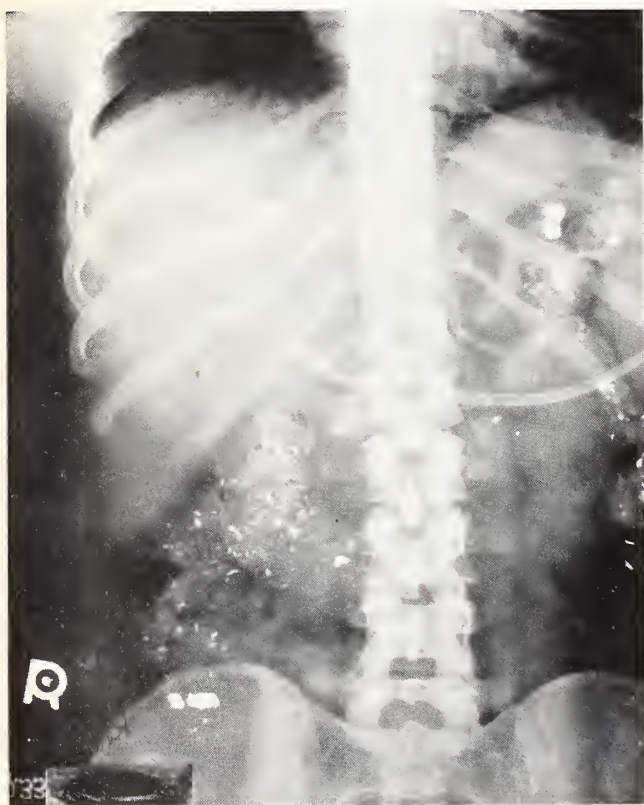


Figure 1.



Figure 2.

*(Answers on page 244)*



# The Treatment of Adolescent Adjustment Reactions in the Community Hospital

By WILLIAM BAUER, M.D./CHICAGO

*The adolescent reactor is simply the child who has arrived at the horizon of puberty with a set of feelings that have been repressed since the beginning of the latency period. When these feelings were repressed, during the first five to seven years of life, he did not have the physical apparatus to act them out, nor did he have the verbal sophistication to express them. Consequently, we witness a delayed expression of these buried, long forgotten childhood feelings.*

In the "normal" home, during the latency years (from six to eleven or twelve), the child would have had an opportunity to put into words the feelings that he was experiencing. But when the "umbrella of love" that is formed by equal partners in a loving relationship is absent, communications are stifled. There are usually either emotional voids or overly intense, often immature, emotional expressions. These all further the process of repression so that by the time puberty arrives, the conscious mind of the child is separated from his unconscious (comprised of repressed childhood feelings, unresolved conflicts, instinctual strivings, etc.). However, it is precisely these repressed remnants of childhood conflicts which unconsciously determine the behavior of the individual for the rest of his life unless they are brought into awareness, verbalized, and fully integrated into the mainstream of consciousness.

## Principles of Treatment

Usually, the behavior that brings the adolescent reactor to the hospital, when interpreted, means, "I have never felt secure. I feel rejected, hurt and consequently, angry with myself, my parents and the world in general." His language is symbolic behavior rather than word symbols. The goal of the hospital staff must be to attempt to understand what the patient is trying to communicate by his behavior and to help him ver-

balize it rather than act it out. In order to accomplish this goal, it is very important to maintain security by adhering to the principles of treatment discussed below.

*Physical security* means adequate staff, an open-ended admission (i.e., if the patient is told that he will only be admitted for a few days or weeks, he will simply maintain good control until that time expires and will be discharged with no real change) and of course, a physical plant that is secure—where the patient can not escape, hurt himself, or others. A patient must be made to feel that he will only be discharged when he has learned to talk about his feelings rather than act them out.

*Emotional security* implies consistency on the part of all staff members to present a united front to the teenager. The staff must act in complete agreement with the policies of the unit, they must communicate freely with each other about problems, and they must support each other on decisions with regard to discipline. All staff must participate in the day to day control of the patients' maladaptive behavior so each adolescent will feel secure. In other words, the patients must not be allowed to manipulate the staff to achieve privileges. And, of course, it goes without saying, that the staff members must not be using the patient to gratify their own unconscious needs.

It is only after the adolescent has tested the physical and emotional integrity of the facility, that he can (trust) feel free to express his emotions verbally. The verbal expression of feelings is entirely new to adolescent reactors, so they need much support and guidance at this stage. In order to develop the emotional security further, all communications by staff with relatives, other than routine reassurances, should be done in the presence of the patient or by the patient himself during phone or visiting privileges.



WILLIAM BAUER, M.D., is an Attending Psychiatrist at Chicago Lakeshore Hospital and a consultant psychiatrist at Farkosh and Edgewater Hospitals. He is also Medical Director of North-west Human Resources Center, Rolling Meadows.

## **Progression of Behavior**

During the usual course of events which follow this type of treatment approach, the patient will initially test the physical plant. Then, in small ways, he will begin to probe the emotional integrity of the staff. First, to see if they believe in what they are doing. Secondly, to see if the staff members have the emotional integrity and if they care enough to keep the patient from acting out in maladaptive ways. This testing will often lead to the need for restraints or seclusion rooms for varying lengths of time. Once the patient feels secure, rapid progress can be anticipated unless perceptual distortions are present (e.g., Schizophrenia), in which case ancillary somatherapies must be employed. Some patients, especially those who are repeaters or who have "beat the system" in other hospitals will be extremely difficult. These adolescents will be compelled to test the staff harder and longer than others before they reach the feeling of security that is vital to their further growth.

Careful diagnostic studies must be carried out, as previously mentioned, to be sure that the child is not schizophrenic, brain damaged, or psychopathic. With each of these, of course, the approach is modified.

## **The Role of the Family**

During the period of hospitalization, it is important that the family receive information which will help them understand what is happening and what is expected of them, if the child is to be returned home. If the parents are willing to enter group sessions, lectures, seminars, etc., there is hope for a low rate of recidivism. But, if the parents are resistive to participation in the program, the child will probably do better, after inpatient treatment, if placed in a neutral or treatment oriented residential care facility.

Aftercare is as important as the hospital treatment itself, because without reinforcement of the newly learned patterns the patient will quickly regress to his former method of physical communication. The family should continue therapy for several months to a year following the hospital period. This can be done either by the use of multiple family groups, parental groups, or peer groups (where adequate control is available). The shibboleth of a legal-probationary period, or a suspended sentence contingent on good behavior are helpful, but cannot replace the sheer moral determination, integrity and conviction of the primary therapist.

A clear distinction should be made between the above course and hospitalization for observation and evaluation which is a short-term procedure, usually for a specific period of time. This type of hospitalization is primarily for diagnostic evaluation, environmental manipulation, and/or refuge.

## **Case History I**

A 17-year-old boy was constantly in trouble at home and with the police for various petty offenses. He was finally hospitalized. In family sessions, it was noted that the father was usually dismayed at the constant negative interchanges between the boy and his mother. It seemed that a dysequilibrium had developed in the family relationship. The mother and son were intensely involved with each other in a verbal sadomasochistic relationship while the father was "left out" of the picture. The mother was the dominant parent, but the discipline was weak in the home.

Almost immediately after hospitalization, the youngster began to "test" the physical security of the hospital and escaped one time. He was returned by the police. After several times in conventional restraints, he was placed in sheet restraints for several hours with constant attendance. Following this period of time in sheet restraints, wherein he felt secure for the first time in his life (this was verbalized in retrospect several months later), his behavior improved dramatically and he was soon discharged. The patient was placed in a neutral setting following hospitalization and has subsequently returned to school.

## **Case History II**

A 15-year-old girl was admitted to the hospital following three previous hospitalizations at other facilities. She was constantly testing the staff. One significant staff member, a nurse, disrupted the united front of the staff by stating repeatedly to the patient that he did not believe in restraints and was only applying them "because they were ordered."

The results of this treatment were disastrous. The patient acted out more intensely, making numerous suicidal gestures and attempts to escape. Finally, it became known that the inconsistency in approach was existent. The patient was transferred to another facility where she made an uneventful recovery, after a series of unsuccessful testing maneuvers.

*(Continued on page 227)*



# Spontaneous Conversion from Vertex Presentation To Transverse Lie During Labor as Detected By Migration of a Fetal Scalp Electrode

BY TIMOTHY T. MILLER, M.D./CHICAGO

## A Case Report

A 36-year-old Black, gravida 3, para 2, Class B diabetic, was admitted on July 2, 1975, at 37 weeks' gestation for delivery, after amniocentesis indicated fetal maturity. Her last term pregnancy was in 1956. Both prior gestations terminated in normal spontaneous deliveries.

Her last menstrual period was October 29, 1974. After routine screening disclosed glycosuria, a fasting blood glucose value of 180 mg% was reported. Lente insulin, 15 units daily, was then prescribed. On July 2, 1975, the fetal biparietal diameter was 8.9 cm, the lecithin/sphingomyelin ratio was 2.8, and the creatinine was 1.8 mg%. The estimated fetal weight was 3400 g. Induction of labor was begun with the vertex at station -1 and the cervix 2 cm dilated and 50% effaced. A fetal scalp electrode was attached after rupture of membranes. No fetal distress was noted during labor. Oxytocin was administered at the rate of 10 to 17 mu/min.

The fetal scalp wire was noted to be shortening about 5 hours after the induction was begun. The cervix was then 3 cm dilated. Because no presenting part was palpated, a scout film of the abdomen was obtained (Fig. 1), showing a trans-

verse lie with fetal scalp clip in place. The monitor was recording well. A low transverse cesarean section was performed with delivery of a 3232 g girl with an Apgar score of 8/9. The scalp clip was still in place.

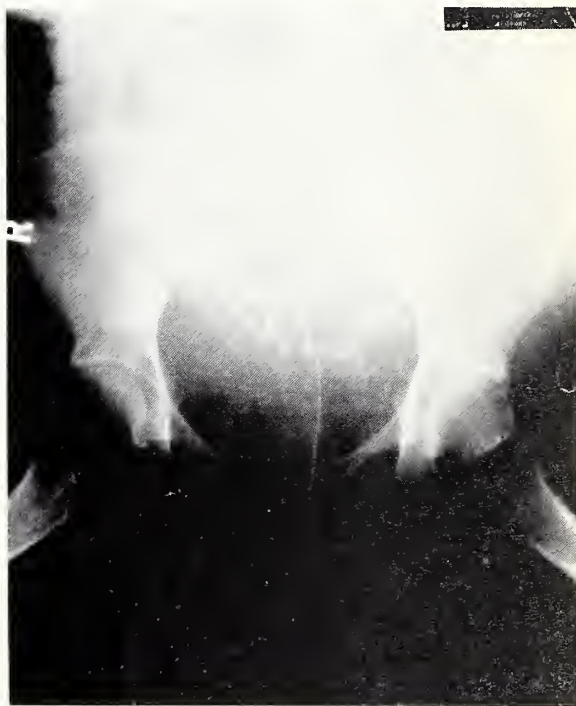
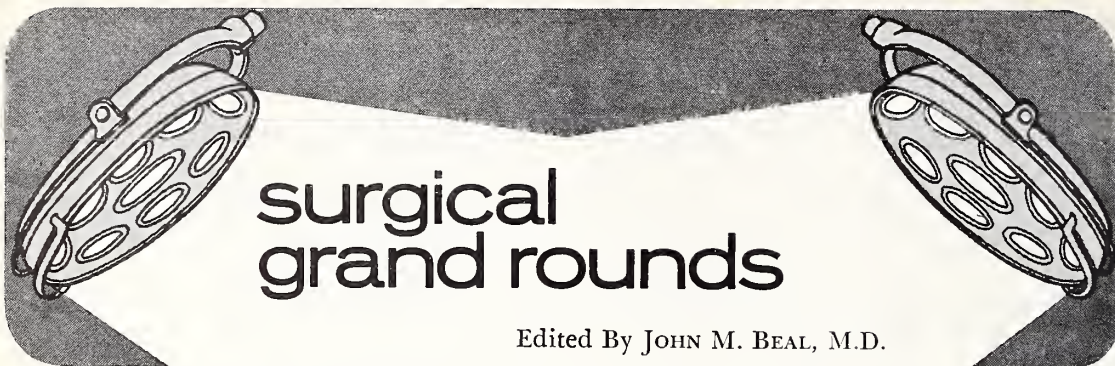


Figure 1. Roentgenogram of abdomen, showing fetus in transverse to oblique lie with scalp wire in place. Head was in vertex position when electrode was first attached.



TIMOTHY T. MILLER, M.D., is Assistant Professor of Obstetrics and Gynecology at the University of Illinois Hospital and the University of Illinois Abraham Lincoln School of Medicine.



*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of November 25, 1975.*

## Compartmental Compression Syndrome

**Dr. Michael Verta:** A 43-year-old man was brought to the Emergency Room in an intoxicated state, complaining of deep, boring pain in his left calf, swelling and inability to walk. He did not remember the mechanism of injury and stated that he could have fallen or could have been attacked. The injury occurred approximately 12 hours prior to admission.

Past history included alcoholism and heroin addiction seven years earlier, from which he claimed to have withdrawn. Other history was unremarkable. Physical examination disclosed an obviously intoxicated, belligerent, disheveled man. The left lower extremity was swollen, with multiple abrasions and contusions. The calf was tender to compression. Peripheral pulses were present and equal bilaterally. Sensation and motion in the toes were present and normal but there was exquisite calf pain on dorsiflexion or plantar flexion of the foot. The remainder of the physical examination was unremarkable.

Initial laboratory evaluation included a normal hemoglobin, urinalysis, serum electrolytes, and coagulation profile. Radiologic study of the left tibia, fibula and femur was negative. A tentative diagnosis of deep venous thrombosis was made and the patient was admitted to the hospital for bed rest, elevation of the leg, and intravenous heparin administration. An SMA-14 at the time of admission was normal except for marked elevation of the CPK.

### Diagnosis Made

During the next 12 hours, the peripheral pulses remained present and normal in quality;

however, the patient began to notice progressive numbness and difficulty in moving the toes. Venous flow studies using Doppler ultrasound and impedance plethysmography showed left popliteal vein occlusion. His white blood cell count rose to 17,500. Because of loss of sensation and the progressive loss of motion of the toes, together with the elevated CPK, a diagnosis of compartmental compression syndrome was made and intravenous heparin administration was terminated immediately.

Fasciotomy was done through three separate skin incisions in an effort to decompress all four compartments. A short skin incision was employed, then a long-handled scissors was used to split the fascia subcutaneously down to the level of the malleolus medially and laterally and to the tendon Achilles posteriorly. Following the skin incision, a considerable amount of edema fluid was noted in the soft tissue space. As the fascia was incised, the calf muscles bulged through the fasciotomy opening with immediate recovery of color, tone and contractility.

The fourth compartment (deep posterior) was decompressed by retracting the medial head of the gastrocnemius muscle posteriorly and finger dissection of the fascial planes.

### Postoperative Course

Postoperatively, the patient felt considerably better. The next day, the pain in his calf was relieved and he was gaining return of sensation in his toes. His course was then complicated by the development of delirium tremens. This was treated with chloral hydrate and later, with Valium.



After five days he had recovered from the alcohol withdrawal. The edema in the calf had subsided and he was free of pain.

A wound culture taken five days after operation revealed *Serratia marcescens* which was sensitive to Ampicillin. There was no evidence of infection of the compartments, however. The patient was afebrile and his white blood cell count had returned to normal. Eight days later the wound appeared clean with healthy granulations; the muscle was no longer tense and the skin was pliable. At this time, the CPK enzyme level had returned to normal. Primary closure of the wound was done; the skin edges were approximated without tension.

After two days of bed rest and elevation of the leg, ambulation was resumed with minimal assistance from a cane. The patient had a slight residual peroneal nerve weakness.

Two and one-half weeks after discharge, examination in the office revealed the incisions to be well healed. The patient walked well but was required to wear an elastic stocking.

### Further Considerations

In the case presented today, several problems arose which merit further consideration. In any patient who presents with a swollen extremity and a history of antecedent trauma, one must be aware of the possibility of compartmental compression and look for the more subtle early manifestations. One of the earliest findings in this syndrome is severe, deep pain in the calf due to muscular infarction. One may mistakenly consider such pain to be indicative of venous thrombosis and this may even be confirmed by blood flow studies. But venous flow studies may be falsely positive in these cases due to external compression of the popliteal vein by swollen, tense muscular compartments. Marked elevation of the CPK will, however, serve to differentiate between these two problems. It goes without saying that the administration of heparin in the presence of tissue destruction will only serve to aggravate the problem; thus, one must take pains to make definitive diagnosis before instituting heparin therapy. The treatment of the compression syndrome in this patient, of course, consisted of cessation of anticoagulation and compartmental decompression by fasciotomy.

The place of fasciotomy in extreme injury has been a subject of controversy for a very long time. Jepson in 1926 was the first to demonstrate the importance of adequate venous return in preventing ischemic contractures, but not until 1945 did Dennis describe the efficacy of fasciotomy in limb salvage following total venous interruption.

Battlefield experience in World War II, Korea and Viet Nam has demonstrated the importance of fasciotomy in the treatment of arterial injuries and extremity trauma, and this was underscored by the civilian experience of Shires and Patman, Thompson, and Ernst.

The commonly accepted indications for fasciotomy in compartmental compression are as follows: 1) the presence of total venous interruption with patent arterial inflow; 2) significant distal soft tissue damage, with or without concomitant vascular injury; and 3) prolonged ischemic time due to major vascular occlusion with subsequent revascularization. The first two are fairly well-recognized; however, prolonged ischemia is still a subject of debate with some advocating early aggressive use of fasciotomy and others voicing a more conservative opinion.

Usually the degree of urgency for repair of an arterial injury is determined by the apparent viability of the skin, but outward appearance can be quite deceptive in these cases, since the relative viability of ischemic nerve and muscle is quite limited compared to that of skin. It has been shown by Malan and Tattoni that neural degeneration will begin four to six hours after onset of ischemia and that by 12 hours, almost 90% of muscle fibers will show microscopic evidence of degeneration with about half of these irretrievably damaged.

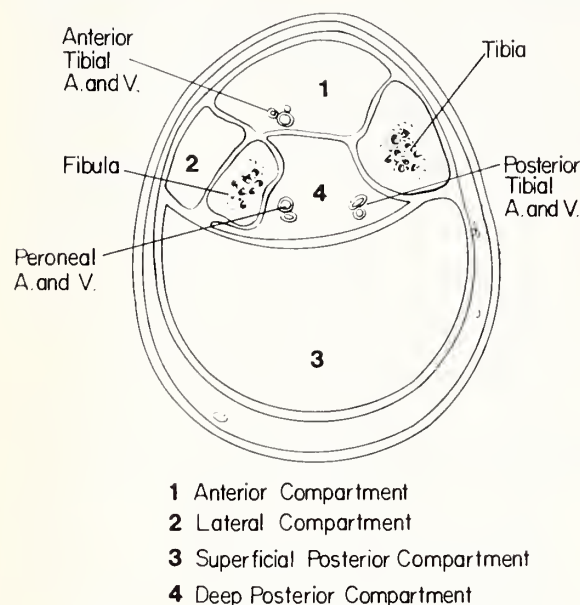
The presence of pedal pulses is also not a reliable sign of circulatory integrity to the muscles. In compartmental compression syndrome, the basic problem is due to interruption of flow in the medium-sized arteries and venous return of the calf muscles. Under these circumstances, pedal pulses will be present.

It is generally agreed that areas of skin anesthesia, digital paralysis, or foot drop should be considered late warning signs of serious limb ischemia.

### Reasons for Fasciotomy

In the compartmental compression syndrome, the rationale for fasciotomy is that ischemia, especially when associated with some degree of venous obstruction, will cause muscle in the fascial compartments to swell, leading to increased intracompartmental pressure, which may impair capillary flow. Many state that the pressures generated in this manner are really insufficient to cause serious vascular compromise, but we think that anyone who has seen tense, pale muscle bulge through a fasciotomy incision and become red again feels that this argument may be somewhat academic. One can also cite as precedents venous gangrene of the gut or the loss of a swollen pedicle flap.

In 1956, Britnall, et al., in reviewing a series of peripheral extremity injuries, showed that if swelling is severe enough and persists long enough without correction, eventual amputation may be required even though main arteries and veins remain patent.



**Figure 1. Diagram of four fascial compartments of leg.**

**Dr. James Yao:** Figure 1 is a diagram of the four fascial compartments of the lower limb. The three compartments that are quickly recognized are the anterior, lateral and superficial posterior compartments. The deep posterior compartment is probably the crucial one in success or failure of many arterial repairs and it is frequently ignored. It contains the flexor digitorum and flexor hallucis muscles, the popliteus muscle at the level of the knee, and the posterior tibial muscle.

Several approaches have been devised for opening these compartments. DeBakey, in 1946, proposed opening four compartments through two incisions—one opening the anterior and lateral compartments and the other, at the medial inferior border of the tibia, opening the superficial posterior compartment, and then entering the deep compartment from that. In 1968, Kelly proposed using a fibulectomy approach for access to all four compartments, since the fibula in the adult has no significant weight bearing or supportive function other than serving as a point of attachment for the ligaments of the ankle. The middle three-fifths or so of the fibula is a rather clean area and is not badly missed. Thus, Kelly's approach is to remove the middle portion of the fibula either from below or through the lateral compartment and then open all fascial compart-

ments through the periosteal bed. Occasionally, a medial counterincision is made for additional decompression of the superficial posterior compartment.

Among those experienced in extremity trauma, the efficacy of fasciotomy is without question. Patman and Shires cite the fact that, in 271 cases of arterial trauma and massive soft tissue trauma of the lower extremity, their amputation rate was less than 4%. Ernst, in a series of 40 patients in whom he employed fasciotomy early and aggressively, had no amputations. He concluded that three-compartment fasciotomy is adequate following acute occlusions and revascularization since soft tissue damage and concomitant arterial and venous injuries, fibulectomy is the most suitable.

### Summary

In summary, fasciotomy is often overlooked or employed in a too little, too late manner in managing the severely injured lower extremity. It is useful as both an adjunctive procedure in cases of significant arterial injury, particularly when there has been a delay in repair, and as a primary procedure in soft tissue trauma without arterial injury. An appropriate conclusion to these remarks is a quote from Dr. Jesse Thompson: ". . . (Fasciotomy) is used to its greatest advantage when the need is recognized early. . . ." ◀

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# Faculty Resources of Family Physicians in Illinois

BY KENNETH F. KESSEL, M.D., A.B.F.P./BERWYN

*The nation has witnessed an exponential growth recently in the number of Family Practice residency programs. The State of Illinois is no exception. In the past five years, approved Family Practice residency programs throughout the nation increased from 30 to 240. During the same period, Illinois approved programs increased from 2 to 20. This rapidity of growth has created a crisis in securing qualified family physician faculty. The shortage is likely to continue for the remainder of this decade. At the same time, a number of eligible family physicians have voluntarily shown an interest in evaluating their knowledge by taking the rigorous two day board certifying examination which must be repeated every seven years in order to remain board certified.*

*Illinois currently has 313 board certified family practice physicians. Thus, one could assume that these diplomates have sufficient knowledge and interest to make them candidates for part or full time positions in the 20 Illinois programs. It is also recognized that many non-board certified family physicians qualify as teachers, but for various reasons were unable to take the board examination. Illinois currently has 3,400 general practitioners/family practitioners, 1,700 of whom belong to the Illinois Academy of Family Practice.*

## Purpose

The Illinois Academy, Committee on Teaching, in liaison with the Society of Teachers of Family Medicine, sponsored a project booth at the annual Illinois Academy of Family Practice Convention in May, 1975. The booth was given a prominent location so it was virtually impossible to attend any of the educational seminars or tour the displays without passing it. The booth was the only provider of coffee and tea within the display area and, as an added incentive, distributed attractive "Teaching Is Beautiful" buttons with the Society of Teachers of Family Medicine symbol, for those filling out questionnaires. Furthermore, the booth provided an on-going color videotape of typical family practice resident teaching situations as well as brochures and large Illinois maps showing the locations and vital statistics of existing programs.

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KENNETH F. KESSEL, M.D., is director of Family Practice Training Programs at MacNeal Memorial Hospital, Berwyn, and Professor and Acting Head of the Department of Family Practice at Abraham Lincoln School of Medicine, Chicago. Dr. Kessel is also chairman, Clinical Division of Family Practice at MacNeal Memorial Hospital. He is a consultant and Charter Fellow of the American Academy of Family Practice.

Figure 1

## Family Practice Residency Programs

Existing Programs	Faculty/Resident Ratios	
	Current	Projected
Christ Community Hospital, Oak Lawn	2/8	5/24
Illinois Masonic Medical Center, (U. of I. affiliate)	2/7	2/10
West Suburban Hospital, Oak Park	3/3	3/18
St. Francis Hospital, Peoria	2½/15	5/24
USAF Medical Center, Scott AFB	4/16	5/19
Methodist Hospital, Peoria School of Medicine, University of Illinois	2/14	3/14
Rockford Medical, Education Foundation, Rockford School of Medicine, University of Illinois, and associated hospitals	3/27	4/27
Cook County Family Practice Residency Program, Chicago	3/16	5/24
Lutheran General Hospital (U. of I. affiliate)	2/6	3/24
Family Practice Teaching Program, MacNeal Memorial Hospital (U. of I. affiliate), Berwyn	3½/15	5/18
St. Mary of Nazareth Hospital Center, Chicago	4/7	7/17
St. John's Hospital (S.I.I. affiliate), Springfield	4/11	5/16
Swedish Covenant Hospital, Chicago	2/15	2/15
University of Illinois, College of Medicine, Danville	1½/4	1½/8

Figure 1 is a reproduction of the information distributed describing the current ratio of faculty to residents and the projected (or needed) ratio for 1980. Of the 14 programs reporting, 17 additional faculty will be needed by 1980. If the previous 5 year growth rate continues for the next 5 years an additional 40 to 50 faculty will be needed, making it necessary to recruit as many as 67 full time family practice faculty by 1980.

Figure 2 shows the IAFP convention attendance analysis and the number of physicians actually filling out a questionnaire.

**Figure 2**  
**IAFP Annual Convention Survey**

<b>1. IAFP convention attendance</b>			
a. M.D.'s	594		
b. Guests	305		
c. Exhibitors	151		
d. Total	1,050		
e. M.D.'s filling out questionnaire	93	(16% of M.D.'s attending convention)	

Three questionnaires were disqualified because of non-physician status, non-state residence and inappropriateness respectively, leaving a total of 90 questionnaires properly filled out. The questionnaire is shown in figure 3.

**Figure 3**  
**ILLINOIS ACADEMY OF FAMILY PHYSICIANS**  
**TEACHING RESOURCE QUESTIONNAIRE**

1. Name _____
2. Address _____
city                      state                      zip
3. Phone number _____
4. Sex _____ 5. Age _____
6. Year of graduation from medical school _____
7. Year of board-certification _____
8. Are you presently teaching medical students and/or residents?
9. Are you presently teaching in an approved Family Practice Residency Program?
10. Under what conditions would you consider teaching in a Family Practice Residency Program?
11. If not, please state reasons: _____

Figures 4 through 10 are a summary of the data collected. Special attention should be given figure 9 by persons interested in faculty recruitment, the names and addresses of the physicians in these areas can be obtained by writing: Kenneth F. Kessel, M.D., Chairman of 1974-1975 IAFP Committee on Teaching, 3249 South Oak Park Ave., Berwyn 60402.

**Figure 4**  
**Age distribution of**  
**IAFP convention physicians responding**

	Number	Percentage
a. Below 30	0	0%
b. 30-40	10	11%
c. 40-50	15	17%
d. 50-60	41	46%
e. 60-70	20	22%
f. 70-80	4	4%
g. Over 65	12	13%

**Figure 5**  
**Sex distribution of IAFP physicians responding**

	Number	Percentage
a. Male	88	95%
b. Female	5	5%

**Figure 6**  
**Status of certification of responding physicians**

	Number	Percentage
a. American Board of Family Practice	49	53%
b. Without Boards in Family Practice	44	47%

**Figure 7**  
**Family physician IAFP respondents presently teaching**

	Number	Percentage
a. Approved Family Practice Residency Programs		
I. With Boards in Family Practice	20	38%
II. Without Boards in Family Practice	9	20%

**Figure 8**  
**Family physicians who are presently not teaching but have an interest in becoming active teachers, part or full time**

	Number
a. With Boards in Family Practice	18
b. Without Boards in Family Practice	16



**Figure 9**  
**Family physicians interested in teaching**

Location	Number
Arlington Heights	1
Bellville	3
Chicago	9
Clarendon Hills	1
Crystal Lake	1
Decatur	1
Des Plaines	1
Elmhurst	1
Fairfield	1
Geneva	1
Irvington	1
Joliet	1
Kankakee	1
Lebanon	1
Melrose Park	2
Mount Prospect	1
Oakbrook	1
Oak Forest	1
Oblong	1
Oswego	1
Palatine	1
Planewood	1
Prospect Heights	1
Streator	1
Sullivan	1
Troy	1
Urbana	1

**Figure 10**  
**Reasons for not wanting to teach**

a. Age	2
b. Distance	4
c. Health	1
d. Too Busy	2

### Discussion

Even though no definite conclusions can be realized from this small sample (i.e. 16% of the physicians at the convention, 9% of the members of the IAFP and 3% of all general practitioners and family physicians in Illinois), we felt some useful information was obtained to suggest the direction of future efforts and studies. The fact that so few physicians stopped to furnish the needed data is in itself significant. One might expect the data to be more readily received by those interested in education, as indeed it was (66%). The age sampling also indicated those family physicians most likely to go to IAFP conventions, 85 (94%) were over age 50.

Another question to which the committee addressed itself was the difference in attitudes toward teaching between practicing family physicians with or without board certification. Of the 49 boarded family physicians 20 (38%) were presently teaching in approved Family Practice programs and 18 (37%) stated an interest in

becoming part time or full time teachers. Of the additional 11, 5 (10%) were undecided and 6 (12%) were definitely not interested. The non-boarded sample revealed 9 (20%) who were presently teaching in approved Family Practice programs, 2 (5%) who were teaching in non-approved Family Practice programs and 16 (36%) with a definite interest in teaching. 15 (33%) were definitely not interested in teaching and 3 (6%) were undecided.

This suggests that there is greater interest among the boarded group: 75% either currently teaching or interested in doing so, as opposed to 60% of the non-boarded group. The difference is even more obvious if one compares boarded family physicians who are definitely not interested (12%) in teaching to unboarded family physicians who are *not* interested (34%).

### Conclusion

In conclusion, there is an identifiable pool of forty-one family physicians in Illinois who have an interest in teaching. The most frequent reason given for not wanting to teach was distance from a training program (Fig. 4). Also, board certification was a significant variable regarding interest in teaching. Finally, there seems to be a strong reluctance of family physicians to identify their interest or lack of interest in Family Practice training programs (only 16% of physicians registered at the convention stopped to fill out forms). ◀

### Adolescent Adjustment

(Continued from page 220)

#### Summary

Security in the sine qua non of a successful treatment program for the adolescent reactor. When the patient finally feels secure, he is able to begin serious introspection and integrate at a more mature level of adaptations. He can then learn to talk rather than act. It is important that these new patterns of adapting be reinforced with several months of post hospital treatment in order to effect permanent change in both the patient and his family. ◀

#### References

1. Aichhorn, August: *WAYWARD YOUTH*. New York: Viking Press, Second Edition, 1966.
2. Bauer, William: "The Other Side of the Coin." *Illinois Medical Journal*, February, 1970.
3. Bauer, William: "The Umbrella of Love." *Illinois Medical Journal*, July, 1975.

## Abstracts of Board Actions

(Continued from page 198)

1. Endorsed the immunization program;s to cooperate with public health offi-
2. Encouraged county medical societieocally;
3. Urged physicians to: (A) Volunteer ambulatory patients, including those in nization clinics; (B) Encourage alltheir immunization at the mass clinics; the high risk category, to obtain taccine and equipment supplied by public and (C) Refrain from charging for voians may charge their usual, customary health authorities. However, physing the vaccine.  
and reasonable fees for administerients to: (A) Provide vaccine and equip-
4. Urged IDPH and local health departms to physicians offices, upon request, ment remaining from the mass cliniceceive the immunization from their perso that those patients choosing to rlyze large community institutions in the sonal physicians may do so; (B) Utiny people as possible with minimal dis-immunization efforts to reach as maify the present legal consent form to ruption of employment; and (C) Modand.  
make it brief and easier to understo protect physicians from potential mal-
5. Rejected the need for legislation t  
practice litigation.

### Council-Committee Appointments

Several hundred ISMS members were appointed to one-year terms on the Society's various councils and committees for 1976-77.

### IDPA Drug Manual

Upon recommendation of its Committee on Drugs and Therapeutics, the Board urged IDPA to add 17 drugs in the Drug Manual. It also recommended that IDPA continue its present policy of retaining two refills on public aid prescriptions as authorized by the prescribing physicians; urged that no changes be made on the prescription items currently listed other than the 17 additional drugs mentioned earlier; and urged IDPA to relist items which are now carried as prescription items, but are legally non-prescription to the "over-the-counter" category. It was also recommended that the following OTC items be retained in the Drug Manual: acetaminophen in pill and liquid form; aspirin in various strengths; essential Iron products and Vitamin preparations for children and adults.

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## ISMS House of Delegates

### Interim Session

November 6-7

Peoria Continental Regency

#### Saturday, November 6

- 8:00 a.m. Delegates Registration  
9:00 a.m. Credentials Committee  
10:00 a.m. First Session of the House of Delegates  
Reports of Officers and Staff  
Submission of Resolutions  
11:30 a.m. District Caucuses  
2:00 p.m. Reference Committees B, D, and

#### Constitution and By-laws

- 2:45 p.m. Reference Committees A and C

#### Sunday, November 7

- 8:00 a.m. Delegates Registration  
8:30 a.m. Credentials Committee  
9:00 a.m. Second Session of the House of Delegates  
Adjournment



# MEN OF MEDICINE, 1776-1976

## Medical Licensure in Illinois: An Historical Review

By KENNETH H. SCHNEPP, M.D./SPRINGFIELD

*Of the many interpretations and connotations associated with the word license, the definition found most compatible with its use in medicine may be quoted as follows: "A right or permission granted in accordance with law by a competent authority to engage in some business or occupation, to do some act, or to engage in some transaction which but for such license would be unlawful."<sup>1</sup>*

This is mentioned because the original licensure act in Illinois is entitled "An Act for the Establishment of Medical Societies," and to qualify as true licensure it must satisfy the requirements of the above definition.

### Background

But before describing in detail the original act, it might be of interest to paint a background picture of conditions in the great Illinois Territory at the beginning of the nineteenth century. This Territory was created February 3, 1809. Its extent and boundaries were set by intricate political and military maneuvering, having to do with

the institution of slavery and the struggles between England and France. Transportation to this area was almost entirely by water. Thus, when Illinois was carved out of the Territory to become the twenty-first State of the Union, the overwhelming percentage of the population lived on the banks of the Wabash, Ohio, Mississippi and Illinois Rivers.<sup>2</sup> Living conditions were primitive. Disease, including devastating epidemics, was the rule. There was the constant danger, not only of Indians, but of outlaws and military crossfire.

In those days, medicine was as primitive as the log cabin. It is true that the groundwork for the so-called scientific method had started. The basic sciences, the very foundation of modern medicine, were on the move.<sup>3,4</sup> Still, the spectacular explosion of knowledge in the latter half of the nineteenth century had not yet begun. Whatever was known or discovered took months or years for dissemination, and knowledge had no easy way of penetrating into Illinois. There were, practically speaking, no journals and very few texts. Much of medical knowledge was based on trial and error. As a result, there were all varieties of practitioners: botanists, root doctors, eclectics, Indian herb doctors, homeopaths, hydrotherapists, vegetarians, regulars and others.<sup>5</sup> The cures were widely touted and the failures quietly buried. Viewed from the present day, much of the therapy in vogue was actually harmful, including as it did "puking, purging, and



KENNETH H. SCHNEPP, M.D. is clinical professor of medical education at Southern Illinois University Medical School in Springfield where he has practiced for over forty years. Dr. Schnepf is on staff at Memorial Medical Center, St. John's Hospital and Springfield Community Hospital. He is also a Fellow of the American College of Surgeons and the International College of Surgeons and a past president of the Illinois Surgical Society and the American Medical Writers' Association.

Dr. Schnepf's interest in licensure stems from membership on the Illinois Medical Examining Committee from 1954 to 1974. He has been involved with the Examination Institute of the Federation of State Boards, of which he is now a board member, and was a member of the committee that constructed the first FLEX. He is serving his second term as a member-at-large of the National Board of Medical Examiners.

bleeding." Medical schools were few and training was brief and dogmatic. This was a time in which almost anyone could call himself doctor, and did!

### **Passage of the First Act for Licensure**

The new Legislature of Illinois, meeting in Kaskaskia, must have been impressed by a certain sense of urgency to do something about the control of medical practice. Illinois became a state December 3, 1818. "An Act for the establishment of Medical Societies" was approved March 24, 1819, less than four months after statehood was attained. Among the signatures at the end of this act was that of Shadrack Bond, the first governor of Illinois.

The Act was patterned after acts passed in New Jersey in 1772 and 1790.<sup>6,7</sup> (In fact, subsequent to 1772, most of the then existing states passed similar acts.) The basic mechanism was the creation of legal medical societies to which was given the authority to examine and license. The Act provides, "That the state shall be divided into four Medical districts, in each of which there shall be held a board of Physicians."

The Act goes on to say, "That said societies established as aforesaid, shall have power to examine all students who may make application for that purpose; and grant diplomas under the hand and seal of the president, before whom such student may be examined. Provided, that nothing in this act shall be construed as to prevent any person coming from any other place from practicing in this state, such person producing to either of said societies a diploma from any respectable university of the United States, or any other country. And the person receiving such diploma shall upon the receipt of the same, pay to the treasurer of said society the sum of ten dollars for the use of said society."

### **Provisions for Enforcing the Act**

The next section states: "That from and after the organization of said medical societies, no person not having a diploma, or previously practicing in the state, shall commence the practice of physic and surgery, in either of the aforesaid districts, until he shall have passed an examination as hereinafter directed; and if any person shall so practice previous to having obtained a diploma, he shall thereafter be disqualified from collecting any debt or debts incurred by such practice, in any court or before any magistrate of this state."

There was also provision for interim examinations by five physicians who were empowered to

award a certificate of practice until the next annual meeting when such certificate could be exchanged for a regular diploma.

The Act also provided, "That it shall be the duty of every physician, residing within the bounds of either of the aforesaid districts, to keep a true and accurate record of all births, deaths, and diseases which may take place within the vicinity of his practice." These statistics were to be forwarded periodically to the president of the society for publication.

Attendance at meetings of the societies was obligatory with a penalty of five dollars for non-attendance.

The last section provided that the board of physicians "may examine medical bills, which may be by the patient considered exorbitant, and make such deductions as may to them seem reasonable, . . ." If this Act be compared in essentials with the definition of licensure, the requirements seem to be met, although the penalties provided for non-compliance were not very strict.

The sense of urgency felt by the first general assembly did not persist. "An Act repealing an Act entitled 'An Act for the Establishment of Medical Societies'" was approved January 3, 1821. The precise reason for this is not known but it is significant that the state capitol had been moved from Kaskaskia to Vandalia on December 4, 1820, after intricate political maneuvering.

### **Another Act is Passed**

Whatever happened, the pressure for control of the practice of medicine persisted. "An Act prescribing the mode of Licensing Physicians" was approved January 15, 1825. Fundamentally this was an extension of the Act of 1819. Jurisdiction was extended to thirty-three counties the language was strengthened. However, the penalties for non-compliance were essentially the same. One significant change was the substitution of the word "Censor" for that of "President." This use of the term has persisted in county society constitutions and by-laws for over a hundred years.

It is fair to assume that this act did little to affect the practice of medicine. A variety of practitioners existed from a variety of schools of many philosophies. The apprentice pathway to medical practice was commonly followed. The M.D. degree was accepted as authority to practice medicine without either examination or a license. Medical "schools" were chartered freely and all were profitable, increasing the professional stand-



ing of the faculties. Small wonder that attendance was not enforced, the curriculum was increasingly abbreviated, and many of these "schools" became diploma mills.<sup>8</sup> In fact, the very formation of the American Medical Association was caused by these flagrant practices.

### States Unite for Medical Examiners

Doctor N. S. Davis, a young delegate to the New York State Medical Society in 1844, presented a set of resolutions for consideration. He proposed that all examinations for license to practice medicine be conducted by state boards independently of medical schools. These resolutions lay on the table for a year. When finally discussed, it was pointed out that should New York alone adopt such a radical course, students would abandon New York schools in favor of other states. These arguments led to the calling of a national convention. In Philadelphia, on May 7, 1847, the American Medical Association was born.<sup>9</sup>

Unfortunately, the new organization was not able to convince legislators that the establishment of state boards to examine and license practitioners was designed to protect the public. On the contrary, the many varieties of practitioners (as opposed to the regulars) pointed out that the idea of penalties, restrictions and examinations was only designed to enable the regular profession to enjoy a monopoly of the practice and to restrict the liberty of the citizen in the employment of whomsoever he pleased. This argument carried considerable weight with individuals coming as it did so soon after the Revolutionary War.

### Illinois Sets a Precedent

There was practically no progress in national reform until the Act of 1877, in Illinois, provided the opening wedge for true control of medical education. Actually there were two acts involved. The first was a State Board of Health Act, approved May 25, 1877. Several days later a Medical Practice Act was approved. The new Board of Health was given authority to enforce the provisions of the Medical Practice Act in addition to other responsibilities.

### Eight Strong Men

The enthusiasm with which the new Board of Health began its duties reflects the personalities of the members of that Board. John H. Rauch, M.D., (1828-1894) of Chicago became presi-

dent.<sup>10</sup> He was a graduate of the Department of Medicine, University of Pennsylvania. His early years of practice were in Burlington, Iowa. About 1858 he accepted a chair in the Chicago Medical College. During the Civil War he was medical director of the Army of the Potomac under General McDowell and of the Nineteenth Army Corps under General Banks. Soon after, on returning to Chicago, he became Commissioner of Health. Dr. Rauch promoted the establishment of a good water supply, the development of a sewer system and the organization of park districts. It is reported that he strongly supported the passing of the Act of 1877. Subsequently, when it became apparent that the secretary was to be the executive officer of the Board, he relinquished the presidency and acted as secretary for the following fifteen years.

Doctor E. W. Gray of Bloomington was elected secretary of the organization at its formation. However, he resigned six months later and was succeeded by Doctor Anson L. Clark of Elgin, who was a graduate of the Eclectic Medical Institute of Cincinnati. Dr. Clark had practiced in Illinois for 17 years. The Treasurer of the Board was Doctor Horace Wardner of Cairo, an 1856 graduate from Rush Medical College. He had practiced for 23 years in Illinois.

Other members included Reuben Ludlam, M.D., who had graduated from the University of Pennsylvania in 1851, and had practiced in Illinois for 27 years. Doctor W. M. Chambers was originally listed as being from Elgin but moved to Charleston, Coles County. He received his diploma from Transylvania University in 1843 and had practiced 41 years in Illinois. Newton Bateman, LL.D., of Jacksonville was a unique individual. He was state superintendent of schools in the Civil War era and was the original corresponding secretary and traveling agent of the Illinois State Teachers Association at its formation in Bloomington in 1853. At the time of his appointment he was president of Knox College in Galesburg. John Milton Gregory, LL.D., was regent of the Illinois Industrial University. A former baptist minister, he had twice been elected state superintendent of public instruction in Michigan. His school, the first land grant institution in Illinois, was renamed the University of Illinois in 1885.

### Provisions of the Act

The Act of 1877 allowed the Board of Health to issue certificates authorizing the practice of

medicine. They were to "prepare two forms of certificates, one for persons in possession of diplomas or licenses, the other for candidates examined by the Board." The Act further required that, "If a graduate in medicine he shall present his diploma to the State Board of Health for verification as to its genuineness. If the diploma is found genuine, and if the person named therein be the person claiming and presenting the same," the Board could act. If on the other hand "it be found to be fraudulent, or not lawfully owned by the possessor, the Board shall be entitled to charge and collect twenty dollars of the applicant presenting such diploma."

### **Many Problems Face the Board**

Notwithstanding this penalty, the new Board found it had real problems. It was presented with many diplomas, but the difficulty was in deciding the legitimacy of the school granting the degree. The Board also received diplomas belonging to someone else. The Act contained the ubiquitous "grandfathers' clause" which provided that anyone in practice ten years be granted a certificate. An affidavit was all that was required to verify ten years practice.

As a result of these problems, the Board adopted two resolutions in its first annual report:<sup>11</sup>

"Resolved that on and after July 1, 1878 the Board will not consider any medical school in good standing which holds two graduating courses in one year; and

"Resolved, that on and after July 1, 1878 the Board will not recognize the diplomas of any medical school which does not require of its candidates for graduation the actual attendance upon at least two full courses of lectures, with an interval of six months or more."

This action was the foot in the door. The next step was adoption of regulations designed to implement the Act, and gradually a system of recognizing only "approved" schools evolved. However, the Act of 1877 did not specifically provide the authority for the Board to set standards. They could not approve or disapprove a medical school once a ruling by a "friendly" attorney general had been made.

### **The Board is Granted More Power**

As a result of this controversy, an amendment was introduced in the 32nd Assembly (H.B. 483-March 1881) by Mr. Shumway. This provided for the "good standing" clause and reached sec-

ond reading with some significant additions requiring medical student to: have graduated from high school; study medicine for four years, including medical attendance 6 months a year for three years; train for a year in a general hospital; be examined before receiving a diploma. (All of these conditions had been recommended by the A.M.A.) However, there must have occurred some discreet political maneuvering because in the bill finally approved only the "good standing" clause was retained.

With this legislative go-ahead, the Board plunged into a routine of approving or disapproving medical schools. This was a milestone for medical education in the United States. Questionnaires were sent out, school catalogues consulted, and actual inspections were done. A report on medical education by a committee of the Board was published in the Third Annual Report, 1881, and presented in detail the requirements for "approval."<sup>12</sup> A significant paragraph in the recommendations stated: "There is a palpable absurdity in expecting to make skillful physicians of illiterate students by a mere dint of reading them lectures, even when accompanied by quizzes and examinations."

The recommended requirements for approval were very similar to the deleted requirements of H.B. 483-1881. Conditions were such, however, that the licensure road was rocky and the Board was plagued by legal actions. There was much controversy over just precisely what constituted grounds for refusing or revoking licensure. The mere term "unethical or unprofessional conduct" was too vague to meet specific cases.

Nevertheless, the policies and actions of the Illinois Board of Health of 1877 were distinctly revolutionary. It was the first time that any legislative authority of any state in the United States boldly graded medical schools and estimated their ability to educate physicians.

### **Loophole Prohibits Revocation of Licenses**

There was, however, a serious loop hole in the Act of 1877. As written, and later interpreted by the Supreme Court, the Board was unable to revoke a license granted before 1877. So the Act of 1887 was designed and passed. This did extend the authority of the Board to discipline all licentiates, except the grandfather. The Supreme Court held<sup>14</sup> that licentiates by examination or diploma were a distinct class, and, in basic essentials, these requirements need not be met by those entitled to practice under the "grand-



fathers' clause." Even the Act of 1899 did not entirely correct this. Finally an amendment in 1908 gave the Board the right to discipline the grandfathers.

### **Chiropractic and Osteopathy Emerge**

The next significant change in the licensing act occurred shortly after the publication of Daniel David Palmer's theory of chiropractic and the founding of his school in 1895, and the publication in 1897 of the autobiography of A. T. Still who founded osteopathy. Political pressures resulted in the passing of a new medical practice act in 1899 which specifically excluded "those who desire to practice any other system or science of treating human ailments who do not use medicines internally or externally, and who do not practice operative surgery. . . ."

Another significant part of this Act was a new provision granting exemptions "to any person who ministers to or treats the sick or suffering by mental or spiritual means, without the use of any drug or material remedy." The fine hand of lobbyism was increasingly detectable!

It is still to be noted that provision was retained to license anyone who "presents a diploma from a legally chartered medical college in Illinois of good standing." At least, this was a change from recognizing a diploma from medical schools in other states or countries. Unfortunately, there appeared to be no restrictions on becoming legally chartered.

### **Eighteen Years Reformation**

The next 18 years were characterized by profound changes in medical education and licensure. Radical changes had been needed for a long time. The American Medical Association was founded on this belief and continued to advocate what were considered self-interest proposals. They emphasized the need for licensure examinations conducted by an external agency not functionally associated with medical schools. The Carnegie study of 1910, conducted by Flexner,<sup>15</sup> has universally been credited with originating reform in medical education. However, many specialty organizations, since the formation of the A.M.A. in 1847, had been created as advocates for reform.

The Association of American Medical Colleges (AAMC) was founded in 1876 to promote reform from within but that effort was abandoned in 1883, only to be revived in 1890.

A National Confederation of State Medical

Examining and Licensing Boards was organized in 1891 to establish uniform requirements and examinations. First the Confederation recommended three year medical courses. In 1896, they urged graduation from high school as a minimum requirement, and by 1904 had adopted a recommended uniform curriculum for medical schools. Also in 1904, the AMA Council on Medical Education was formed. It met for the first time in 1905, with the AAMC and the licensing boards.

In 1902, a Confederation of Reciprocity was founded in Chicago to promote just that between states. However, after six years it represented only 15 states, so in 1912 this organization merged with the National Confederation of State Medical Examining and Licensing Boards to form the present Federation of State Medical Examining Boards of the United States.

In 1906, the AMA Council on Medical Education began exposing inferior schools by publishing the examination results of their graduates in various states. The next year, this Council began to inspect and grade medical schools. This system developed into the grading of class A, B, and C schools.

### **Flexner Report Explodes Medical Education**

So the Flexner Report was the finger that pulled the trigger on a loaded gun! The advantages of the report were its timeliness, its use of a foundation not associated with medicine, and the fact that it was a survey by a layman. This combination stimulated widespread publicity. The rest is history; medical schools that did not adapt were quickly closed. The AMA adopted the methods used by the Illinois Board of Health in 1877. They classified and graded all medical schools. There were complaints from the wounded about authoritarianism and the scientific elitism of organized medicine. It was, and still is, argued that medical practitioners were pushing higher standards for licensure to reduce competition.

However, there were other problems that needed to be solved. Wide variations in hospital facilities, cultural assets and schools made some states more sought than others. Many of the state boards glossed over the credentials and training of prospective practitioners if they agreed to practice in less attractive areas. Thus dissimilar requirements evolved from state to state and added to the confusion and complaints about reciprocity.

In 1915, the National Board of Medical Examiners was founded, as a joint venture of several groups who recognized the lack of uniformity in state requirements, to administer examinations for licensure purposes. These examinations did more to standardize teaching in medical schools than any other factor.

### **Department of Registration and Education Established**

There was little change in Illinois licensure until the reorganization of 1917. At this time, the Board of Health became the Department of Public Health and its licensing powers were transferred to a newly created Department of Registration and Education. The parent Act was a new Civil Administrative Code that placed all licensing procedures under one department. Medicine was to find strange bed fellows in the company of well diggers, horse-shoers, beauty operators, real estate agents, architects, and many others. The newly organized Medical Examining Committee became a hearing body and an examining body—nothing more. It lost all administrative authority. It retained only one important power; the Director of the Department could not act without the advice, in writing, of a majority of the Medical Examining Committee.

The first director of the new Department of Registration and Education was Francis W. Shepardson of Chicago, appointed by Governor Lowden. In 1921, William Henry Harrison Miller of Champaign became director.

"Colonel" Miller<sup>16</sup> was a school teacher for 26 years, 18 of these in Illinois, before he took an active interest in political life. He served two terms in the House of Representatives, from 1917 to 1921. He ran for Lieutenant Governor in the Republican Primary as a running mate of Len Small but was defeated. Small went on to win the governorship and promptly appointed Miller as the second director of the Department of Registration and Education.

### **Scandal**

According to available records, Miller took an exceedingly liberal view of the Medical Practice Act and began to blatantly sell licenses. He was indicted for his operation by a grand jury in May, 1922. He refused to resign, but Governor Small, because of public clamor, removed him as Director several months later. Miller was found guilty by a jury in January, 1923, and fined \$1000.00.\* This relatively mild penalty was in-

fluenced by the arguments presented by Miller's attorneys that although Miller was guilty of the acts indicated, he was violating no law and, therefore, the acts did not constitute a crime!<sup>17</sup>

This argument was based on the wording of the original Civil Administrative Code of 1917, which stated: "None of the above enumerated functions and duties shall be exercised by the Department of Registration and Education, except upon the action and report in writing of persons designated from time to time by the Director of Registration and Education to take such action and to make such report, for the respective professions, trades and occupations as follows:" The ambiguity and vagueness of this is obvious!

### **The Present Medical Practice Act is Passed**

The Act of 1917 ran into further difficulties because of legal action taken by the chiropractors. Eventually a Supreme Court Decision<sup>18</sup> invalidated part of the 1917 Act. This led the Legislature to pass the Act of 1923. Changes consistent with the court decision were made and the wording of the Civil Administrative Code was strengthened.

The 1923 Act has remained the basic Medical Practice Act. True, there have been amendments and changes in the regulations governing the Act over the years. Still, the present Act represents a distillation of the needs and controversies of many groups<sup>19</sup> over a hundred years and is a perfect example of the evolution of law. On the whole, it is a good Act and comparable with other state acts. Yet it does have some weaknesses. The lack of administrative control has been one of these.

A further weakness has been the inability to quickly deter further practice of medicine when further harm to patients is an obvious probability. Under the present Act, an individual is innocent until legally proven guilty, which may take years. In the meantime, the accused is free to practice. There must be some legal method by which the burden of proof can be shifted to the accused. This is a feature in the present Act for

\*It might be of interest to note the subsequent career of "Colonel" Miller. After retirement from the Department of Registration and Education, Miller returned to the House of Representatives. As an extracurricular activity, Mr. Miller, with the help of seals and other paraphernalia that had disappeared from the Department after his original indictment, went into business again. He sold fake diplomas and licenses extensively in a clever ring that involved Class B and C medical schools and exceedingly insecure and incomplete reciprocity arrangements with other states. Eventually he was indicted, convicted, and spent a term in prison in addition to a fine.

*(Continued on page 248)*



# Doctor's News

**NEW LAW PROTECTS PARTICIPANTS IN SWINE FLU PROGRAM**—Manufacturers and those facilities and organizations participating in the national swine flu immunization program will be protected from nuisance lawsuits because of a bill passed August 10, by Congress. The National Swine Flu Immunization Program of 1976 (PL 94-380) extends protection only to those who provide free-of-charge inoculations. The new statute applies provisions of the existing Federal Tort Claims Act to claims of injury resulting from the vaccine and requires that all claims be filed only against the U.S. Government. Also included in the statute is a requirement that all persons receiving the vaccination give written consent. Joyce C. Lashof, M.D., Illinois Department of Public Health director, has announced that there will be a seven to eight week delay in the start of Illinois' immunization program, now being re-scheduled for the middle of October. IDPH is charged with administration of the program in Illinois and has decentralized its responsibility for inoculation to local health departments.

**CONTINUING MEDICAL EDUCATION**—Four courses offering Category I credit for the AMA Physician's Recognition Award will be held at the Copley Memorial Hospital, Aurora, on Saturday, October 16, 1976. Course selections are 1) Fluid and Electrolyte Balance; 2) Office Dermatology; 3) Diagnosis and Treatment of Arrhythmias and Management of Coronary Artery Disease; and 4) Pulmonary Function and Blood Gases. Deadline for registration is September 27. For further information contact: AMA Department of Meeting Services, 535 N. Dearborn St., Chicago 60610.

**VISIT DISNEY WORLD** from September 15 through December 15, and participate in a specially prepared vacation program which includes 4 days and 3 nights at the Royal Plaza Hotel in Disney World at Lake Buena Vista, Florida, a 2-day, 16 attraction ticket book for the Magic Kingdom Theme Park and other features at \$64.00 per person based on double occupancy. For further information call Miss Brooks toll free at 800-327-2990 and identify yourself as an ISMS member.

**NEW DIRECTOR WANTED**—The Board of Vocational Education and Rehabilitation is searching for an individual to fill the post of Director of the Division of Vocational Rehabilitation. All applications should be addressed to: Mary E. McKean, Chairman, Selection Committee, 447 Arlington St., Elmhurst 60120.

**A HEALTH AND NUTRITION EXAMINATION SURVEY** of persons aged 6 months through 74 years will be conducted by the U.S. Public Health Service in counties throughout the country this fall. Examinations will be conducted in the survey's mobile examination center and will provide the first look at change in the nutritional status of the population over time through data on dietary intake, laboratory tests, body measurements and clinical assessments. All information collected is held in strict confidence. The persons selected for the sample are asked to sign a release permitting reports of findings to be sent directly to their physicians. No treatments or medical advice are given to the examinees by the examining staff. It is hoped that any necessary followup care will be advised by the examinee's own physician.

**THE 1977 AMA NATIONAL LEADERSHIP CONFERENCE** has been set for January 20-23, at the O'Hare Marriott Motor Hotel, Chicago.

**ICCME WORKSHOP ON "INTRODUCTION TO CME TECHNIQUES"** to be repeated on October 29-31, at the Oak Brook Hyatt House, Oak Brook. This Workshop will be of *special* importance this year to CME planners in hospitals and specialty societies throughout the State as they gear up to help Illinois physicians satisfy the new Mandatory CME Law.

This Workshop takes account of research findings that the most effective CME occurs in the clinical setting when colleagues teach and learn from one another. Accordingly, content is focused on (1) identification of learning needs as physicians perceive them, and (2) use of group problem-solving techniques. Workshop Moderator is Donald F. Pochly, M.D., M.Ed., Chairman, Department of Health Sciences Education, University of Health Sciences/The Chicago Medical School. Registration is limited to 20. Participants will earn 14 hours of AMA Category 1 credit. For further details on program, schedule, and cost; write or call the Illinois Council on Continuing Medical Education, 55 East Monroe, Chicago 60603 or telephone: (312) 236-6110.

**PHYSICIANS IN THE NEWS**—Dr. J. Robert Buchanan, a nationally recognized medical educator and administrator who is currently dean of the Cornell University Medical College in New York City, has been appointed president of Michael Reese Hospital and Medical Center. Dr. Buchanan is expected to assume his office at Reese late this year. He has been dean at Cornell since 1969, and his many activities and accomplishments include chairman-elect of the Association of American Medical Colleges' Council of Deans, chairman of the national advisory council of the Children's Television Workshop, clinical director of a Welfare Medical Care Project, and establishment of a Comprehensive Care and Teaching Program.

C. H. William Ruhe, M.D. has been named senior vice president for scientific affairs of the American Medical Association. Leonard D. Fenninger, M.D. succeeds Dr. Ruhe as AMA Group vice president for medical education. Dr. Ruhe has been a member of the AMA staff since 1960 and secretary of the AMA Council on Medical Education for the past 10 years. Dr. Fenninger joined the AMA in 1973 after serving as associate director of the National Institutes of Health. Alfred Soffer, M.D., of Glenview, has been named editor of the Archives of Internal Medicine, a scientific journal published by the AMA. Also, Alexander R. Lerner, Director of ISMS Division of Health Care Delivery And Field Service, has been appointed to serve on the AMA's Federation Communications Planning Group.

The Board of Directors of Health Care Service Corporation (a Blue Cross and Blue Shield Plan) elected as its Chairman, Richard M. Burrige, Hinsdale. Mr. Burrige is a Senior Vice President of Alliance Capital Management Corporation.

In another recent election, Ralph Wynn, M.D. became president of the Chicago Gynecological Society, Albert Gerbie, M.D., president-elect; Harry Waddington, M.D., vice-president; Antonio Scommegna, M.D., secretary; Holden K. Farrar, Jr., M.D., assistant secretary and Philip C. Williams, M.D., treasurer. Vinod C. Patel, M.D., has been appointed program director for Christ Hospital's residency program in obstetrics and gynecology.



## Unanimous Positive Action



For many years the medical profession has been on the defensive. This position has been forced upon us largely by government and the media and has not given us time to act positively. Perhaps it is because we have not anticipated problems adequately. We must go off the defensive, however, without being offensive. Take total body CAT scanners or cardiac surgery units. We should not have waited for third-party carriers or for laws establishing HSAs but, in order to avoid unnecessary duplication of expensive equipment, should have elaborated criteria and standards and reached agreements voluntarily. If the medical profession, for example, would speak out vigorously the hospitals, which sometimes make such huge and superfluous capital expenditures, could not reasonably act against the overwhelming weight of the public opinion which we could arouse.

We must get together and act in unison, make the necessary compromises and accept the inconveniences. For the alternative is the loss of our freedom to make medical judgments that are crucial to the good care of our patients.

*Joseph H. Skom, M.D.*

Joseph H. Skom, M.D.



## ATTENTION ALL PHYSICIANS!

As knowledgeable and efficient as your Medical Assistant is, it would be impossible for her to stay abreast of the frequent revisions in the Medicare Regulations. To *improve your cash flow and increase efficiency* in handling Medicare paperwork, CNA Medicare has developed a series of new, improved workshops for your office personnel. These workshops will not be a day-long continuum of lectures. Instead, they will feature:

1. A brief introduction.
2. The showing of a 20 minute slide and tape presentation.
3. Two (2) hours of workshops where your office personnel can sit down with one or more of our Public Relations Representatives to discuss claim problems relevant to you.
4. 1/2 hour of group questions-and-answers.
5. Lunch provided by CNA Medicare.
6. One or more guest lecturers selected by

the Illinois Society of AAMA to speak on relevant medical topics.

Remember! A knowledgeable Medical Assistant is your Key to office efficiency and improved cash flow.

C—the AAMA Executive Memo and our Medicare Newsletter for notices of seminars!

N—courage your Medical Assistant to attend!

A—nticipate the results!

Schedule of programs:

October 3, 1976	Mt. Vernon
October 24, 1976	Freeport
November 7, 1976	Jacksonville
December 5, 1976	Carthage
January 9, 1977	Danville
February 6, 1977	Peoria
March 6, 1977	Chicago

For further information contact: Jean Fauts, 1815 Hoover Drive, Normal 61761, or Nancy Kruger, 645 Evergreen Lane, Bradley 60915.

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## The Right to Die

Would it not be right to let every patient die without unnecessary prolongation of misery? Couldn't an ordinary, worn-out person, if he understood to ask for it, be allowed peace in his last days? What a pity that at the present time we physicians are routinely obliged to "do all we can" for every patient.

Since ancient times, it has been of central importance for the profession to emphasize that a physician always saves lives. Lately, the ever-increasing technical developments in medicine have offered new possibilities for prolonging life. Under certain circumstances, however, the finest treatment produces the opposite result from that originally intended. The service to life begins to acquire inhuman features.

In a way, it is easy for a physician to always do "all that is possible." At least, then he cannot be accused of anything in court.

But just as a healthy person has a right to live, a sick and old person has a right to die. (Irma Kerppola-Sirola: "The Death of an Old Professor." *JAMA* (May 19) 1975, pgs. 728-729.)





# CHICAGO CHAPTER WORKSHOP PART I OCTOBER 20, 1976 SPECIAL MEDICAL ASSISTANTS COURSE

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, INC.

**Moderator:** Mrs. Magda Brown  
Immediate Past President  
A.A.M.A., Illinois Society

**Coordinator:** Mrs. Eunice C. Budzinski  
&- Committee

- 9:30 a.m. Registration**—The Wedgewood Room—Marshall Field & Company  
111 North State Street—Chicago
- 10:15 a.m. Welcome**—Mrs. Anna Albert, President—Chicago Chapter
- 10:30 a.m. "BEHIND CLOSED DOORS"**—William G. Fischer, Ph.D.  
Psychologist, Vocational Expert, and Consultant to the United  
States Department of Health, Education and Welfare (HEW)
- 11:30 a.m. "THE FUTURE OF THE LABORATORY"**—Mr. Henry Hile  
Marketing Manager, Parke DeWatt Laboratories
- 11:45 a.m. "SPECIMEN CARE FROM PATIENT TO RESULTS"**—Mrs. Helga Kasuba  
Laboratory Supervisor (Receiving), Parke DeWatt Laboratories
- Noon "CLINICAL ASPECTS OF ABORTION"**—Richard A. Ziffra, M.D.  
Illinois Masonic Hospital, Chicago—Obstetrics & Gynecology
- 12:30 p.m. Lunch and Fashion Show**—The Wedgewood Room
- 2:00 p.m. TOUR OF PARKE DeWATT LABORATORIES**  
Located at: 111 North Wabash Avenue—Suite 600—Chicago  
(across from Marshall Field & Company—Wabash Side)

**NOTE — Limited Registration:** Deadline date to register, October 12, 1976

*Please detach registration form below and mail with your check to:*

Miss Chris Baker, Registration Chairman  
2729 West 35th Street—Chicago, Illinois 60632

**Registration Form: Chicago Chapter Workshop—Part I—SMAC—October 20, 1976**

**NAME:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **ADDRESS:** \_\_\_\_\_

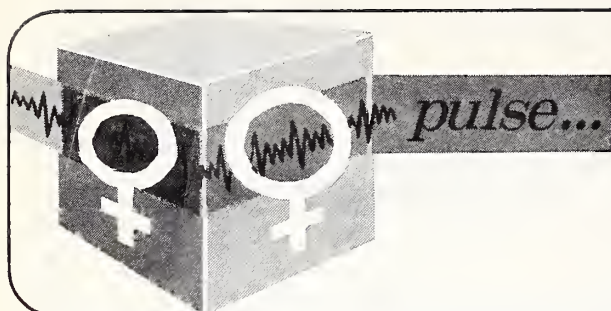
Are you an A.A.M.A. member? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

Chapter: \_\_\_\_\_

Registration Fee: \$7.00 (includes lunch and gratuity)

Make check payable to: *A.A.M.A., Illinois Society, Chicago Chapter*

UNIVERSITY OF BALTIMORE



## of the doctor's wife

MRS. HAROLD KEEGAN, Editor

### Dear Auxilians,

September always signals the resumption of customary routines. As your president, I am looking forward to putting on my travelling togs as fall approaches and beginning my journey around our state.

The Peoria Hilton Hotel is the place-to-be on Tuesday, September 28, for the Patchwork II-Fall Conference. All Auxiliary members are welcome and county officers and chairmen are particularly encouraged to attend. Patchwork II will serve as a combined district meeting for most of our

twelve districts. The day will focus on continuing education for the medical auxiliary. There will also be time for much discussion and comradery.

Many education and informative activities are planned for the day. A legislative session with a particularly practical approach is brewing. We will want to borrow ideas from the reporting state officers and chairmen for local activities. Also the latest data about the implementation of the Swine Flu Immunization Program will be reported and a CPR (cardio pulmonary resuscitation) team from St. Francis Hospital will share their expertise with us.

Finally, we have enlisted the assistance of a newspaper staff member to discuss the media with us. How we communicate our community service message is so important to the continuing involvement of our Auxiliary in health care.

The AMA-ERF shop will be open again. You know that Illinois won First Place nationally for the largest total dollar contribution to AMA-ERF—a combined physician/auxiliary contribution of \$146,772.54. We certainly want to keep this good record.

The Peoria County Medical Society Auxiliary is our hostess and they are planning a lively day. Registration and coffee is at 8:30 a.m. The school day begins at 9:30 a.m. with luncheon being served (\$6.00). The school day will end about 2:30 p.m. Dolores Sheen, Chairman, 4200 N. Brookdale Rd., Peoria 61614, would appreciate your reservations, or call her at (309) 685-3443. If you desire lodging Monday night, join us Monday niters, many State Board members will be present, for dinner. Make reservations through the Peoria Hilton, 501 Main Street, Peoria 61602, or contact Dolores. I hope to see many of you there.

On to other subjects. One of the challenges of being President is to communicate the message of auxiliary. Thus, early in September I will be travelling to Jacksonville (Morgan-Scott County); then to Quincy (Adams County), for a legislative day and on to Geneva (Kane County)



Mrs. Ovitz's Little Red School House.



for a gathering for new members. Shortly after the Peoria conference, I will visit with the Madison County auxiliary in Alton. Then I go to Rockford for the Winnebago County Medical Society's Annual Kick-Off Dinner to which both gubernatorial candidates have been invited. In October, I'll be at the Winnebago County Medical Auxiliary's 25th Anniversary Celebration.

Also, in October, is the annual AMA Auxiliary Conference, a leadership training course offered to a designated number of county presidents-elect from each state. This will be held at the Drake Hotel in Chicago. Illinois is entitled to enroll nine county presidents-elect in this gem of a county auxiliary enrichment program and each county electing a president-elect will have a turn to benefit from the program. My friends, now is the time for those counties without this elected office to revise their by-laws, thereby making them eligible for future invitations to this grass-roots program.

This summer has simply flown by with many hours spent by many people preparing for the



Jean Hodges, 2nd Vice President, and Bonnie Keegan, Editor, at the summer planning meeting held in Sycamore at President Jane Ovitz's home.

events of the next few months. Your support is welcomed and needed and I, for one, am looking forward to a full autumn with you.

Yours truly,  
Jane D. Ovitz

#### Other Notes

ISMS Medical Auxiliary Volunteer badges (pictured below) are available at \$1.25 each from Jane Swanson, Executive Secretary, 122 W. Boston Ave., Monmouth 61462. These can be used this fall by those members who will be assisting with the Swine Flu Program which will be administered by county health departments or the county medical society in those counties without a health department.



The North Central Region of the national auxiliary has been divided. It now contains Ohio, Indiana, Michigan and Illinois.

**Please**, send your **home address** to Jane Swanson, Executive Secretary (address above). She needs the home address of **all** members.

### Special Dates to Note:

#### September 27

ISMS Auxiliary Board meeting in Peoria

#### September 28

Patchwork II Conference,  
Peoria Hilton Hotel  
(Registration 8:30 a.m.)

#### October (late)

AMA Auxiliary Conference

#### November 2

**ELECTION DAY**

#### November 9

Districts 3-11 meeting in Chicago

#### April 24-27, 1977

Annual meeting,  
Holiday Inn Mart Plaza, Chicago

# Emergency—Hazardous Materials

The increasing possibility of incidents involving hazardous materials has brought forward many questions from medical practitioners as well as the general public about what to do when such a situation occurs.

For immediate assistance in emergencies involving hazardous materials contact: CHEMTREC, the Chemical Transportation Emergency Center, at **800-424-9300**. This is a 24 hour a day, toll free number maintained as a public service by the Manufacturing Chemists Association in Washington, D.C.

The State of Illinois, through the Illinois Disaster Plan is also available for direct technical support and assistance in instances involving

radioactive materials or radiation producing machines. By calling **217-782-7860**, one can reach the Illinois Civil Defense Agency Duty Officer in Springfield, who will connect you with the Illinois Radiological Assistance Team. A team member will then advise precautionary measures to be taken before professional personnel arrive. A pamphlet entitled "Care of Radiation Accident Patients" is also available, published by the Division of Radiological Health, Consumer Health Protection, Illinois Department of Public Health.

The Council on Environmental and  
Community Health

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SPRINGFIELD OFFICE: W. J. Nattermann, Representative  
426½ South Fifth Street, Springfield 62701 (217) 544-2251



South America, The Panama Canal  
and the sunny southern Caribbean  
beckon you this winter on the  
Illinois State Medical Society

## Clinics for Crippled Children Listed for October

Thirty-one clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-three general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be seven special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- October 5 Quincy, St. Mary's Hospital
- October 5 Metropolis, Massac Memorial Hospital
- October 6 Cairo, Public Health Department
- October 6 Hinsdale, Hinsdale Sanitarium
- October 7 Sterling, Community General Hospital
- October 7 Flora, Clay County Hospital
- October 7 Lake County Cardiac, Victory Memorial Hospital
- October 8 Division Cardiac, U. of I. Hospital, Center for Handicapped Children
- October 8 Chicago Heights Cardiac, St. James Hospital
- October 11 Peoria Cardiac, St. Francis Children's Hospital
- October 12 Peoria, St. Francis Children's Hospital
- October 12 Rock Island, Moline Public Hospital
- October 12 East St. Louis, Christian Welfare Hospital
- October 13 Jacksonville, Norris Hospital
- October 13 Champaign-Urbana, McKinley Hospital
- October 13 Elgin, Sherman Hospital
- October 14 Springfield, St. John's Hospital
- October 14 Kankakee, St. Mary's Hospital
- October 20 Centralia, St. Mary's Hospital
- October 20 Chicago Heights, St. James Hospital
- October 21 Rockford, St. Anthony Hospital
- October 21 Elmhurst Cardiac, Memorial Hospital of DuPage County
- October 21 Bloomington, Mennonite Hospital
- October 22 Chicago Heights Cardiac, St. James Hospital
- October 22 Evanston, St. Francis Hospital
- October 25 Peoria Cardiac, St. Francis Children's Hospital
- October 26 Peoria, St. Francis Children's Hospital
- October 26 Danville, Lake View Hospital
- October 27 Springfield Pediatric Neurology, St. John's Hospital
- October 27 Mt. Vernon, Good Samaritan Hospital
- October 27 Aurora, St. Joseph Mercy Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, conducted on behalf of crippled children.

for September, 1976

## Trans Panama Canal Air/Sea Cruise

Ports of call include Barbados, Grenada, La Guaira/Caracas, Aruba, Cartagena, San Blas Islands, and transit through the incredible Panama Canal.

Never will your travel dollars have been spent so wisely. Cost for the entire vacation, which includes round-trip airfare via chartered DC-10 jets, every amenity aboard prestigious Sun Line's Stella Oceanis, and all the sun and fun that can be packed into ten glorious days, is as low as \$998.00

We depart Chicago & St. Louis  
On January 5, 1977  
And return on January 14, 1977

Put a little spice in your life, don't let us leave without you.

Send to: Illinois State Medical Society - Suite 3510  
55 E. Monroe Street - Chicago, IL 60603

Enclosed is my check for \$\_\_\_\_\_ (\$100 per person) as deposit.

Name(s) \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

A Non-Regimented **INTRAV** Deluxe Adventure







# RECENT CHANGES

**federal register**

**Providing  
Drug Information  
to Physicians**

**Informational  
Bulletin #433-76**

**National  
Health  
Insurance**

**special report**  
**Malpractice  
insurance:**

**drug  
bulletin**

**Health care doesn't  
need more red tape**

**Drug firms challenge  
'MAC' rules**

**Drug  
Substitution**

**The Common Denominator  
of Health Progress  
RESEARCH**

**Mailgram**



# THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

**Drug substitution** In most states, pharmacy laws, regulations or professional custom stipulate that your on-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original FDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

**MAC** Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

**The drug lag** The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005

UNIVERSITY OF BALTIMORE

## Medical Licensure in Illinois

(Continued from page 234)

psychiatric hospitalization. The active practice of a physician under such conditions is automatically suspended until a court restores civil rights. If such a technic could be applied generally, the legal process would certainly be accelerated.

### Recent Amendments

Two significant amendments to the Act have been passed by the Legislature and signed into law recently. An important but philosophically minor measure was House Bill 2692. This provides for a medical disciplinary committee, with administrative authority, to be funded by biennial relicensure fees paid into a fund restricted solely for this purpose. It is an important step towards enforcing the disciplinary requirements of the Act.

However, philosophically, the alarming amendment to the Act was H. B. 1964, which became effective July 1, 1976. Previous to this date, the Act and all amendments to the Act of 1923, concerned themselves with prelicensure requirements. Now, for the first time, the medical profession in Illinois will be faced with post-licensure requirements euphemistically called continuing medical education! This is not only a change in objective, but also a singular change of emphasis. It is an evolution of the concept that medical knowledge is not static. If an individual practices medicine, he should make of his profession a constant, progressive source of self-education.<sup>7</sup>

### Conclusion

The Illinois Board of Health of 1877 was unique in the United States. It initiated a method of classification of medical schools, enforced premedical requirements, curriculum standards, and licensure regulations. Many states accepted the "approval" of the State of Illinois as authoritative. There is no doubt that the Illinois experience predated the AMA's classification system by about 25 years. It predated the Flexner report by 30 years. For the times, it was an enormously effective legislative instrument.

A license to practice medicine is not a certificate of superior excellence. It is, rather, a minimum standard of competence, set by authorized bodies, legal as well as voluntary, and with, it is hoped, a gradual shift upward of basic required qualifications.

It is true that the Board of Health in Illinois in 1877 initiated the concept of approving medical schools based on evaluations of the schools. It is further noted that at the turn of the century, strenuous attempts were made to coordinate licensure procedures. Two early organizations, the National Confederation of State Medical Examining and Licensing Boards and the Confederation of Reciprocity, merged in 1912 to form the present Federation of State Medical Examining Boards of the United States. This organization has served as the clearing house for an interchange of licensure information and has assiduously worked for higher standards in licensure examinations. The most significant development ever promoted by the Federation was the Federation Licensing Examination (FLEX) which standardized licensing examinations throughout the United States. Illinois was one of the seven original states to help develop and administer the first FLEX in June, 1968.

Of the original Board of Health of 1877, Doctor John H. Rauch was a dedicated and dynamic leader in the field of reform. However, on reading through the five annual reports of the Board, one is impressed by the work and attitude of others of this organization, particularly Newton Bateman, Horace Wardner, John Milton Gregory, and R. W. M. Chambers, who enthusiastically supported the regulations that were evolved for "approval." ◀

### References

A list of references for "Medical Licensure in Illinois: An Historical Review" may be obtained by writing *IMJ*, 55 E. Monroe, Suite 3510, Chicago 60603.

### Acknowledgements

I wish to thank Miss Mary Louise McCreary of the Legislative Reference Bureau as well as the staff of the Illinois State Historical Society and the resources of the State Archives Section for information and assistance. I am also indebted to the Morgue of the Chicago Tribune for factual data. Also to be thanked are Mrs. Wilma Shuey and Mr. David G. Lichtenstein of the Attorney General's Office, and Mr. William W. Downey of infallible memory.



# Recommendation of the Public Health Service Advisory Committee on Immunization Practice

## Influenza Vaccine — Supplemental Statement\*

### Influenza Vaccine Recommendations

Results of the recent field trials provide clear evidence that adults of approximately 25 years of age or older can safely and effectively be immunized against A/New Jersey influenza with a single dose of vaccine. Furthermore, the trials indicate that younger adults and children as young as 3 years old can also be safely immunized but that additional data will be needed before specifying the precise vaccine potency and optimal schedule for them. Although data from additional field studies will be needed to substantiate and complete recommendations for the young adults and childhood age groups, plans for vaccinating all age groups of the population should continue.

Studies underway now and others soon to begin should be completed by mid-to-late-September in time for vaccination programs to proceed.

The current recommendations address the population above secondary school age, namely that 18 years of age and older. Although within this adult group, those 18-24 years old are immunologically distinctive from those 25 years of age and older, as a result of having had less experience with various naturally occurring influenza viruses, all persons in this age group can be given the same potency vaccine. If additional vaccine trials in the 18- to 24-year-old group indicate that sufficient benefit will be derived from a second dose of vaccine, it will be recommended. Furthermore, since whole-virus vaccine produces better antibody responses in the 18- to 24-year-old group, plans should be made to utilize this vaccine for this group.

*For high-risk persons 18 years of age and older one dose of bivalent A influenza vaccine containing 200 CCA units of A/New Jersey/76 (swine influenza virus) and 200 CCA units of A/Victoria/75 should be given. (As noted, if additional field trials show sufficient benefit from a second dose for persons 18-24 years old, it will be recommended.)*

[If you wish to provide high risk persons with monovalent B vaccine (B/Hong Kong/72) this vaccine will be available only through commercial sources. One dose containing 500 CCA units of B/Hong Kong/72 should be given. It can be given at the same time as the bivalent A vaccine

or at another time. If given concurrently, slightly enhanced side effects might be observed. In vaccinating an adult who has previously experienced significant side effects from influenza vaccines, it would be prudent to give the 2 vaccines separately, preferably with the bivalent A vaccine being given a few days or more before the monovalent B vaccine.]

*For persons 18 years or older in the general population one dose of monovalent A influenza vaccine containing 200 CCA units of A/New Jersey/76 (swine influenza virus) should be given. (As noted, if additional field trials show sufficient benefit from a second dose for persons 18-24 years old, it will be recommended.)*

*For persons 17 years or younger in the general population field studies have thus far been inconclusive as to vaccine effectiveness and safety.*

### Precautions

Before being vaccinated, persons known to be hypersensitive to egg protein should be given a skin test or other allergy-evaluating test using the swine influenza vaccine as the antigen. Persons with adverse reactions to such testing should not be vaccinated.

Persons with acute febrile illnesses should not be vaccinated until they have recovered.

### Side Effects and Reactions

Three types of responses to influenza vaccine have been described:

1. Fever, malaise, myalgia, and other systemic symptoms of toxicity occurring 6-12 hours after vaccination and persisting 1-2 days. These responses to influenza vaccine are usually attributed to characteristics of the influenza virus itself (even though it is inactivated in available vaccines) and represent the bulk of the side effects of influenza vaccination. Such effects occur most frequently in persons who have had no previous experience with influenza viruses comparable to the vaccine antigen (s).

\*From *Morbidity and Mortality Weekly Report*, July 23, 1976/ Vol. 25/No. 28, U.S. Department of Health, Education, and Welfare/Public Health Service.

2. Immediate, presumably allergic, responses, such as flare and wheal or various respiratory expressions of hypersensitivity. These reactions are exceedingly uncommon but can occur after influenza vaccination. They probably derive from sensitivity to some vaccine component, most likely to residual egg protein. Although current influenza vaccines contain only a minute quantity of egg protein, they do, on rare occasions, provoke hypersensitivity reactions.
3. Neurologic disorders, including such central nervous system conditions as encephalopathy, with at least temporal association with influenza vaccination. A survey of the medical literature since the early 1950s revealed only about a dozen such reports. Almost all persons affected were adults, and the described clinical reactions began as soon as a few hours and as late as 2 weeks after vaccination. Full recovery was almost always reported.

Three fatalities have been reported in temporal association with influenza vaccination. However, in 2 instances, the patients displayed clinical characteristics and had antecedents which strongly suggested causes other than influenza vaccine, and the third was equally compatible with another viral disease.

## ***Treating Reactions to Influenza Vaccines***

### **From the Center for Disease Control**

The most common reaction to be anticipated is a mild systemic reaction including fever, headache, malaise, and myalgia. These may be expected in up to 5% of recipients and will be more common in younger individuals and those receiving whole virus vaccine. Such reactions may begin several hours after receipt of vaccine and persist for up to 48 hours. Reactions occurring or persisting for longer than 48 hours are uncommon and may be due to other causes. In general, systemic reactions may be treated quite safely with aspirin unless there is a contraindication to the administration of aspirin (e.g. allergy to aspirin, peptic ulcer disease). An alternative analgesic/antipyretic for an aspirin-sensitive individual or an individual for whom contraindications to the administration of aspirin exists, is acetaminophen. In general CDC would not recommend the use of stronger analgesics for these mild systemic reactions. Nor would antihistamines be of value for this type of reaction.

Local reaction consisting of tenderness and erythema at the injection site may be anticipated in a fair number of individuals who receive vaccine. If questioned closely, perhaps as many as

In summary, influenza vaccine has only rarely been associated with severe adverse reactions or permanent disability. Although vaccination relatively frequently causes transient redness and tenderness at the injection site and sometimes causes such systemic reactions as low-grade fever, malaise, and myalgia for 1-2 days, influenza vaccine is considered to be very safe and is quite suitable for widescale, community use.

### **Pregnancy**

A number of prospective studies in the past decade or more have failed to corroborate the association between influenza and increased maternal deaths and fetal wastage. Although there are no persuasive data to document that pregnancy is a risk-factor with influenza, the effect of swine influenza in pregnancy cannot be forecast with assurance.

Physicians generally avoid prescribing unnecessary drugs and biologics for pregnant women, especially in the first trimester; however, there are no data specifically to contraindicate vaccination with the available killed virus vaccine in pregnancy. Women who are pregnant should be considered as having essentially the same balance of benefits and risks regarding influenza vaccination and influenza as the general population.

50% of recipients would complain of such a reaction. In general, these reactions are quite mild and need no treatment. For those who are inconvenienced by such side effects, aspirin or acetaminophen will be reasonable treatment. Although this is a local, inflammatory response which might be ameliorated by administration of an anti-inflammatory agent, CDC considers such agents (e.g. phenylbutazone, corticosteroids, or indomethacin) to have potential side effects which greatly outweigh possible benefit. Aspirin does have significant anti-inflammatory activity and in such cases may be preferable to the use of acetaminophen.

It is anticipated that truly allergic reactions will be uncommon and life-threatening allergic reactions (anaphylactic reactions) will be rare, if observed at all. Mild allergic reactions such as urticaria could be treated with an anti-histamine. More severe, but not life threatening, allergic reactions such as mild bronchospasm would best be treated with the agents customarily employed for such reactions (e.g. epinephrine, aminophylline). Anaphylactic reactions, should they occur, would require emergency medical



treatment in a setting equipped to handle medical emergencies.

One other point, neither an active virus infection nor a vaccine reaction by itself would con-

stitute a contraindication to the administration of aspirin. Finally, be sure there are no other causes of fever before concluding any fever observed is due to the vaccination.

---

**NOTE: The consent form (below) must be signed by each patient.**

---

### IMPORTANT INFORMATION ABOUT SWINE AND VICTORIA FLU VACCINE

Influenza (flu) is caused by viruses. When people get flu they may have fever, chills, headache, dry cough or muscle aches. Illness may last several days or a week or more, and complete recovery is usual. However, complications may lead to pneumonia or death in some people. For the elderly and people with diabetes or heart, lung, or kidney diseases, flu may be especially serious.

It is unlikely that you have built up adequate natural protection against swine flu, since it has not caused widespread human outbreaks in 45 years. You may or may not have protection against Victoria flu, although many Americans had this flu last winter. It was responsible for over 12,000 deaths.

Two vaccines are available: one protects against swine flu only (monovalent), and one protects against both swine and Victoria flu (bivalent). Bivalent vaccine is available only for the elderly and persons with serious chronic diseases.

One shot will protect most people from swine flu during the next flu season (and in the case of bivalent vaccine, from Victoria flu also); however, either a second shot or a different dosage may be required for persons under age 25. If you are under 25 and a notice regarding such infor-

mation is not attached, this information will be provided to you wherever you receive the vaccine.

Most people will have no side effects from the vaccine. However, tenderness at the site of the shot may occur and last for several days. Some people will also have fever, chills, headache, or muscle aches within the first 48 hours.

As with any vaccine or drug, the possibility of severe or potentially fatal reactions must be considered. However, there have been no reported deaths from flu vaccine since the 1940's. In some instances people receiving vaccine have had allergic reactions. You should note very carefully the following precautions:

- People under a certain age should not routinely receive flu vaccine. Please ask about age limitations if this information is not attached.
- People with known allergy to eggs should receive the vaccine only under special medical supervision.
- People with fever should delay getting vaccinated until the fever is gone.
- People who have received another type of vaccine in the past 14 days should consult a physician before taking the flu vaccine.

*If you have any questions about flu or flu vaccine, please ask.*

### REGISTRATION FORM

*I have read the above statement about swine and Victoria flu, the vaccine, and the special precautions. I have had an opportunity to ask questions, and understand the benefits and risks of flu vaccination and request that it be given to me or to the person named below of whom I am the parent or guardian.*

#### INFORMATION ON PERSON TO RECEIVE VACCINE

Name (Please Print) Birthdate Age

Signature of adult vaccinee-parent-guardian

Address of vaccinee

#### FOR CLINIC USE

Clinic Ident.

Date Vaccinated

Manufacturer and Lot No.

## Guest Editorial

(Continued from page 183)

could be the basis for this aspect of peer review. Each department in the medical staff organization, using these standards, should participate in the evaluation of its performance. In defining its strengths and weaknesses, deficiencies can be pinpointed and corrected. Once peer review has been established, the program should be re-evaluated periodically to determine whether there has been an improvement in the quality of patient care.

Cost-containment (utilization review), disciplinary goals (medical audit), and claims review are not totally incompatible with educational objectives. Foundations for medical care, using computer technology, have been effective in identifying excessive costs and over-utilization of services and procedures. By not paying physicians for services rendered, when their performance does not meet the established standards, the educa-

tional message is firmly embedded. To be paid in the future, they must *learn* why the payment was disallowed.

Presently, peer review is a guide to setting up educational programs tailored to improve knowledge, skill, or attitude identified to be weak or inadequate. Future emphasis should be directed to maintenance and improvement of the knowledge and skills of the average physician.

### Comment

The Illinois Accreditation Program is directed to hospital-affiliated physicians. However, the largest patient population is treated in physicians' offices. A sizable number of these patients are treated by office-based physicians who never use hospitals and wouldn't know which entrance to use. How to reach these physicians and motivate them to improve their competence, is a problem with no immediate solution, but is a task to which the Illinois Council on Continuing Medical Education must sooner or later address itself. ◀

## Continuing Medical Education course in

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Loyola University Medical Center  
2160 S. First Avenue  
Maywood, Illinois 60153—(312) 531-3207

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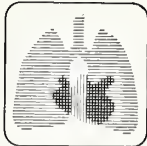
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Park Ridge, Illinois 60068

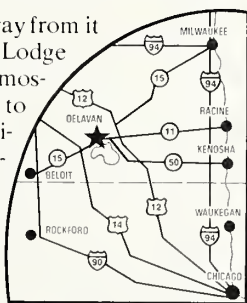
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Please send further information ☐  
TUITION \$40.00 (Including Lunch)  
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Profession \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Viewbox

(Continued from page 218)

**DIAGNOSIS:** *Bile peritonitis*—The axis of the T-tube is in the wrong direction and it should be running from right to left rather than from left to right indicating that it is probably outside the common duct. Following installation of contrast material there was a demonstration of a collection of contrast in the sub-hepatic and in the lateral right gutter as a result of leakage outside the common duct. At surgery the tube was found floating free with a large collection of bile free in the peritoneal cavity.

## COOK COUNTY

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STATE & NATIONAL BOARD REVIEW, BASIC, September 19,  
CLINICAL, September 27  
SPECIALTY REVIEW RHEUMATOLOGY, September 20  
GYNECOLOGIC PATHOLOGY, One Week, September 20  
SPECIALTY REVIEW ORTHOPAEDICS, September 22  
SPECIALTY REVIEW HEMATOLOGY, September 27  
REVIEW COURSE IN MEDICAL GENETICS, 3 days, September 27  
BASIC DERMATOLOGY, One Week, October 11  
SEXUALITY FOR PHYSICIANS, One Week, October 11  
BASIC ELECTROCARDIOGRAPHY, One Week, October 18  
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, October 18  
ADVANCED ELECTROCARDIOGRAPHY, Two & half days, October 25  
MANAGEMENT OF COMMON FRACTURES, One Week October 25  
FLUIDS AND ELECTROLYTES, One Week, September 27

*Information concerning numerous other continuation  
courses available upon request.*

**Address:**  
**REGISTRAR, 707 South Wood Street**  
**Chicago, Illinois 60612**

## EKG of the Month

(Continued from page 212)

**Answers: 1. B,D 2. E**

The ECG shows a delt wave in the upstroke of the QRS best seen in the precordial leads but present in all leads. The vector of the delta wave is superior, and it thus creates Q waves in leads II, III, and avF. This mimics an inferior wall myocardial infarction. There is also left axis deviation on this basis. There is a short PR interval. The delta wave in the prolonged QRS and the short PR interval indicate this is a Wolff-Parkinson-White (WPW) syndrome ECG.

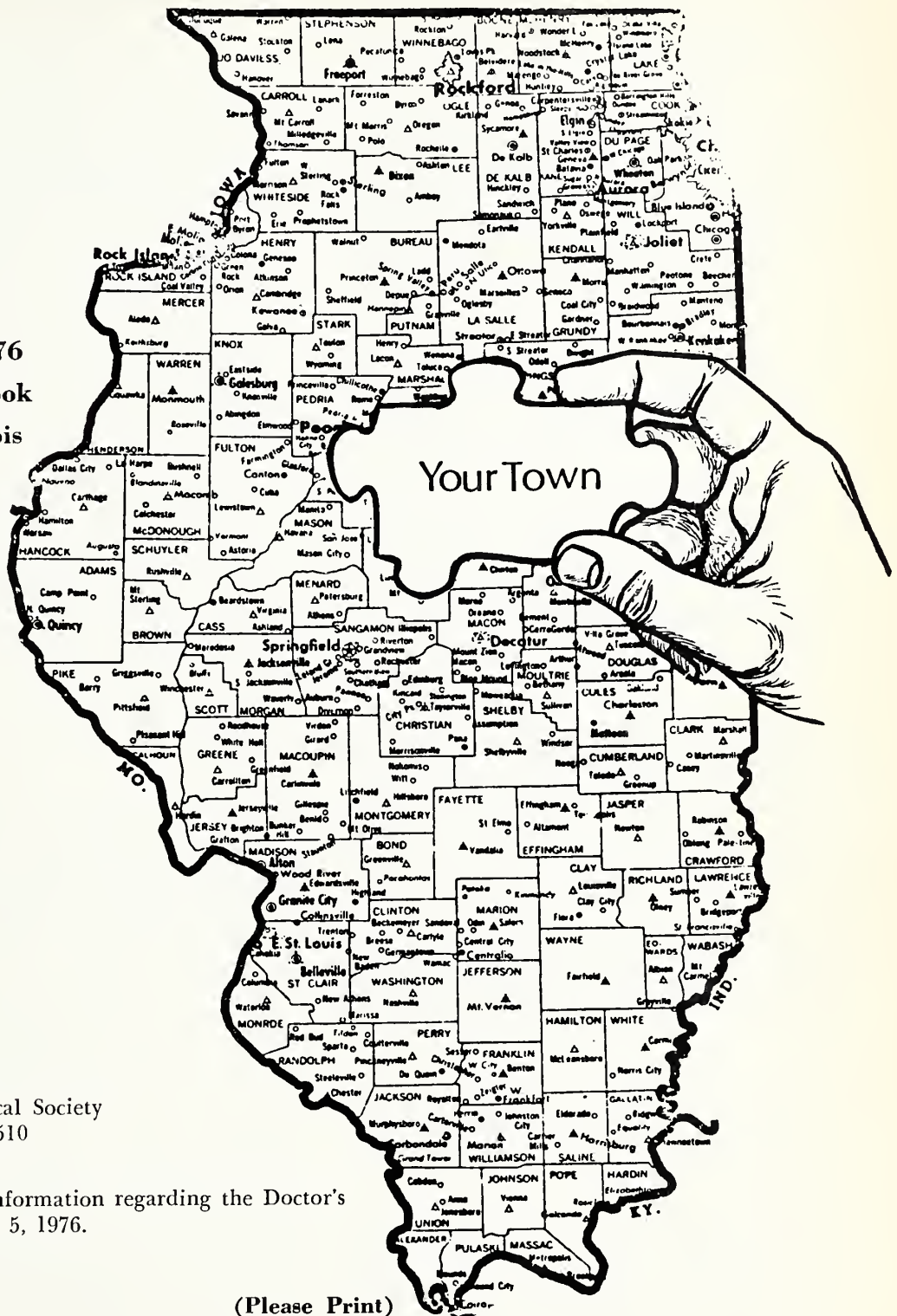
The QRS frequently shows large voltage suggesting left ventricular hypertrophy. This requires no treatment. In Dr. Lamb's study of 128 Air Force men with WPW 78.1% were on flying status (*New England Journal of Medicine* 278: 492, 1968). In the absence of tachycardias, the prognosis for patients with WPW electrocardiograms is felt to be excellent. For further reading on this interesting syndrome see Krikler and Goodwin, *CARDIAC ARRHYTHMIAS*, W. B. Saunders 1975, Chapter 6.



# PUT YOUR TOWN ON THE MAP

## HELP COMPLETE THE MEDICAL CARE PICTURE

December 5, 1976  
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 Oakbrook, Illinois



Doctor's Job Fair  
 Illinois State Medical Society  
 55 E. Monroe—#3510  
 Chicago, IL 60603

Please send more information regarding the Doctor's  
 Job Fair, December 5, 1976.

(Please Print)

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ABINGDON:** Urgent need for FP/GP's. West-Central industrial/farming section. Educational, cultural, recreational environment. Join only physician in modern, well-equipped medical building. No investment. Future assured. Ten minutes to two new JCAH hospitals-470 beds. Convenient to medical centers. Available housing. Contact Ruth Bradway, Box 145, Abingdon 61410. PH: (309) 462-2120. (10)

**ARLINGTON HEIGHTS:** Board Certified Family Practitioner wishes associate who is Board certified or eligible in Family Practice. Modern office located across from Community hospital. Liberal salary and time off for study and vacations. Partnership after one year. Send resume to: Dr. Alan M. Hollett, 605 W. Central Rd., Arlington Heights 60005. (12)

**CAIRO:** F.P. and internist sought. Rural service area—20,000 population. Excellent salary. Fringe benefits including malpractice. Office and staff provided. Med staff privileges in 62 bed acute hospital with peds, OB/GYN, and surgery specialties. Excellent recreation—fishing, hunting, tennis, golf. Private and public schools. Jr., 4 yr. and Med schools nearby. Contact: N. Pettry, 2020 Cedar, Cairo.

**CARBONDALE:** Family physician: Innovative Neighborhood Health Center in Southern Illinois seeks Family Practice Physician to provide patient care and supervise other professionals, para-professionals in clinic setting. Salary negotiable. Position available October 1976. Write: Robert Stalls, Director of Human Resources, City of Carbondale, 602 E. College Street, Carbondale, Illinois 62901, (618) 549-5302. (2)

**CHICAGO:** Medical center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice. Contact: F. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625, 312-478-6000 (2)

**CHICAGO:** Internist: board certified, wanted for association with hospital based medical/surgical group. Very large, active practice. North side Chicago. Unusual opportunity. Write Mr. C. M. Rappaport, Director of Personnel, 5700 North Ashland Avenue, 60660. (12)

**CHICAGO:** Comprehensive Health Care Center in the Metropolitan Chicago area has positions available for primary health care physicians. Center is located in close proximity to Community Hospital. Regularly scheduled hours. Financial arrangements will be discussed and will be commensurate with qualifications. Write or call: P. Pratscher, c/o Joliet Community Medical Center, 450 Prairie, Calumet City, IL 60409, Phone (312) 862-3100. (11)

**CHICAGO:** Physician needed for well established, ultra modern medical center. Full laboratory and X-ray. Congenial working conditions and excellent co-workers. Good hospital associations. No evenings or weekends. Clinic located south side, near lake. Contact, Mr. Lawrence, Booker Family Health Care Center, 747 E. 47th, Chicago, 60653. (312) 624-4800. (1)

**CLINTON:** Population 8500. Opening for solo general practice. Four physicians in General Practice at present. Twenty-five miles from Decatur and Bloomington. Office Available. Recreational facilities excellent. Clinton Nuclear Power Plant under construction 6 mi. east of City. Contact: M. J. Hein, 422 West White, Clinton 61727, AC 217-935-3171. (2)

**COLLINSVILLE-EDWARDSVILLE:** Progressive towns, 15 miles from Downtown St. Louis. Ample recreational facilities, S.I.U. Campus nearby. New Community Hospital will open this summer. Need a qualified Ophthalmologist. No initial investment needed. Excellent opportunity for the future. Contact Mrs. Hall, 657 E. Broadway, East St. Louis 62205, (618-345-0417). (12)

**FAIRFIELD:** Group of 4 physicians, GP, gen. surgeon, Gyn.-OB, and pediatrician, looking for another OB-Gyn. man. Population 6500, excellent hospital facilities, generous salary and all the benefits of corporation assured. Illinois license. Contact S. W. Konarski, M.D., 101 E. Center St., Fairfield, 62837, 618-842-2187. (12)

**FORT MADISON, IOWA:** Opening for 2 FP/GP, OB, Int. in growing industrial city of 16,000 serving 70,000 on Miss. River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, Xlnt, living area, 125 bed accredited hospital. Contact Donald A. Buckert, Sacred Hearth Hospital, Fort Madison, Ia. 52627. 319-372-6530. (12)

**FOX LAKE:** Physician wanted to take over practice, equipment and medical building. Physician urgently needed in area. Convenient financial arrangements if necessary. Fifty (50) miles from Chicago in recreational area. Swimming, boating, fishing, hunting and winter sports. Contact: S. L. Fried, M.D., Box 116, Fox Lake 60020. (312) 587-5001. (10)

**ILLINOIS:** Variety of settings in agencies providing diagnostic, treatment, consultative and advisory services or administrative direction to medical programs. Completion of approved Medical school and 1 year internship/residency in approved hospital required. Must possess or acquire appropriate valid Illinois license before employment. Temporary certification not acceptable. Salary commensurate with skills and experience—Good benefits. Equal Opportunity Employer—Male or Female. Send resume to: Robert P. Gosnell, Manager, Counseling Services and Administrative Recruitment, Illinois Department of Personnel, 521 State Office Building, Springfield, Illinois 62706. (1)



**JOHNSTON CITY:** Southern Illinois—population 4,000 near I-57. Family practice available. Full equipped office. Surgeon in clinic. Possible partnership available. Hospital 6 miles away. 20 miles to SIU. 100 miles to St. Louis Mo. Contact: Mrs. R. A. Rupprecht, 401 N. Allyn St., Carbondale, 62951 (618) 549-3093 (11)

**JUSTICE:** One or two good Family Practitioners needed: lovely new Medical Center (Southwest), on-site Surgery Center, X-Ray, Laboratory, Emergency Room and Pharmacy; complete staff 15 doctors for various specialties who are on staff at nearby 500 bed hospital. Opportunity for future partnership. Contact Dr. E. I. Breslar, Forest Hill Medical Center, 9050 W. 81st, Justice 60458. 312-594-3500. (2)

**McHENRY:** We have openings available for Board Certified or eligible OB-GYN and Orthopaedic physicians on the staff of our 23 physician multispecialty group. Incentive pay from day one with minimum guaranteed draw, malpractice paid, partnership after 1-2 years, excellent fringe benefits. We are 55 miles northwest of Chicago in the Chain-o-Lakes resort area. The Medical Group is physically adjacent to a 147 bed general community hospital and State Trauma Center. Jim Dickson, Personnel Director, McHenry Medical Group, McHenry 60050. (815 385-1050 ext. 332. (2)

**OLNEY:** ENT, Internal Medicine, Dermatology, Ophthalmology needed. 26 MD multispecialty partnership, 15,000+ referral population, new bldg., 1st yr. earnings guaranteed, 200 bed modern hospital, 4 wks. vacation, 2 wks. meeting per yr. Contact: David L. Potter, Adm., Weber Medical Clinic, 1200 N. East St., Olney 62450 (618) 395-4311. (2)

**ORLAND PARK:** Orland Park and far S.W. Chicago office, need general practice physicians, complete facilities both offices. New office bldg. completed Dec. 1, 1976. Contact: C. E. Cornelison, Adm., 10444 S. Kedzie, Chicago 60655, (312) 239-3000. (1)

**OLNEY:** Radiologist to head a new department with another radiologist in a 150 bed hospital with 50 bed addition under construction. Recreational facilities nearby. Community of 10,000. Method of compensation negotiable. Contact Harold Kaseff, Administrator, Richland Memorial Hospital, Olney, 62450. 618-395-2131. (12)

### Doctor's Job Fair

Illinois State Medical Society  
55 E. Monroe—#3510  
Chicago, IL 60603

Please send more information regarding the Doctor's Job Fair, December 5, 1976.

\_\_\_\_\_ Include hotel reservation card.

(Please Print)

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

**PINCKNEYVILLE:** Population 3500—Serves an area of 20,000. Medicaid group partnership of four physicians seeking fifth member. Complete office facilities—2 Blocks from fully accredited hospital. Salary one year—then partnership. Good recreational facilities—near St. Louis. Contact: Clarence E. Cawvey, M.D., 206 North Main Street, Pinckneyville 62274 Phone: 618-357-2131. (2)

**QUINCY:** Emergency medicine opening—rural mid-western atmosphere—Centrally located for outdoor recreation. Modern 280-Bed Hospital and Trauma Center. 2 M.D.'s looking for a partner or part-time Physician. Guarantee inc. and excellent schedule very flexible. Call collect or write, Thomas Fischer, M.D., Blessing Hospital, Quincy, 62301 (217) 223-5811. (11)

**ROCHELLE:** Population 10,000—Two primary care physicians needed. Hospital serves an area of approximately 20,000. Acute general 68-bed hospital with full services, including physical and respiratory therapies. Office space available adjacent to hospital. Located 25 miles from Rockford and a medical college, 17 miles from major university, and an hour-and-a-half from Chicago. Excellent schools, parks and civic organizations. Contact Administrator, Rochelle Community Hospital, 900 North 2nd Street, Rochelle 61068 (815) 562-2181. (2)

**ROCKFORD:** OB-GYN, Board Eligible or Certified. Will support for Solo Practice or Associate. Practice base in Catholic Hospital. Contact: John E. Tillis, M.D., 5670 East State Street, Rockford, 61108, Phone: (815) 398-4110. (11)

**ROCK ISLAND:** Family practitioner, excellent guarantee and office arrangements. Send C.V. to Thomas J. Lavery, 2701-17th St., Rock Island, Illinois 61201 or call (309) 793-1000 (collect) for additional information. (1)

**WAYNE CITY:** Thriving community located in Wayne County in southern-most Illinois. Office facilities furnished for young Family or General Practitioner. No physicians in this community. Contact: Grant Smith, President, First National Bank, Wayne City 62895; 618/895-2118. (2)

BALTIMORE

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## October, 1976

### Anesthesiology

#### REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING

For: All MD's. 5 day course. Oct. 4-8. CME Credit: 40 hrs. AMA Cat. 1. Fee: \$300. Reg. Limit: 8. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Telephone: (312) 733-2800.

### Continuing Medical Education

#### INTRODUCTION ON CME TECHNIQUES

For: All interested in CME. Weekend Workshop, October 29-31. Oak Brook Hyatt House, Oak Brook. CME Credit: 14 hrs. AMA Cat. 1. Fee: \$160. Reg. Limit: 20. Reg. Deadline: October 1. Sponsor, contact: Illinois Council on Continuing Medical Education, 55 E. Monroe, Suite 3510, Chicago 60603. Telephone: (312) 236-6110.

### Couples' Therapy

#### MULTIPLE COUPLES' THERAPY

For: Physicians and Mental Health Professionals. One-day workshop, October 1, 8:30 AM-5:00 PM, Chicago. Speaker: Charles Kramer, M.D., and Jeannette Kramer, F.I.C./C.F.S. CME Credit: 8 hrs. AMA Cat. 1. Fee: \$30. Reg. Limit: 50. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Attn: Belinda M. Stone, Secretary for Workshops/Conferences. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

### Emergency Medicine

#### 1976 ACEP/EDNA SCIENTIFIC ASSEMBLY

For: Emergency Physicians and Nurses. Scientific Assembly. October 11-15. Superdome, New Orleans, Louisiana. Fee: varies. Sponsor, contact: American College of Emergency Physicians and Emergency Department, 241 E. Saginaw, East Lansing, MI 48823. Attn: Martha J. Muth, CME Coordinator. Telephone: (517) 332-6544.

### Family Medicine, Neurology, Surgery

#### NON-INVASIVE DIAGNOSTIC AND THERAPEUTIC PROCEDURES IN CEREBROVASCULAR DISEASE

For: All Physicians. Symposium. Wednesday, October 20, 10 AM-4 PM. Sheraton Tower, Oak Lawn, IL. Speaker: Murray Goldstein, M.D., Assoc. Director, National Institute of Neurological Diseases, Stroke and Developmental Disabilities. CME Credit: 4 hrs. AMA Cat. 2. Fee: \$25 (\$30 after Oct. 1). Reg. Deadline: Reduced fee prior to Oct. 1. Reg. Limit: 250. Sponsor, contact: Heart Association of South Cook County, 2555 West Lincoln Highway, Olympia Fields, IL 60421. Attn: Patricia Rasmussen. Telephone: (312) 481-7383.

### Family Practice

#### SEVENTH FAMILY MEDICINE REVIEW

For: Family Physicians. Symposium. October 17-23. University of Kentucky, Lexington, KY. CME Credit: 48 hrs. AMA Cat. 1; AAFP. Fee: \$295. Reg. Limit: 250. Sponsor: University of Kentucky College of Medicine. Contact: Frank R. Lemon, M.D., University of Kentucky Medical Center, Continuing Education, College of Medicine, Lexington, KY 40506. Telephone: (606) 233-5161.

### Oncology

#### SECOND ANNUAL POSTGRADUATE SEMINAR—THE MANAGEMENT OF COMMON NEOPLASMS: HEAD, NECK, GYNECOLOGICAL AND UROLOGICAL TUMORS

For: Physicians, graduate students in specialties designated—Obstetrics & Gynecology, Urology, Oncology. Postgraduate Seminar in Oncology (2½ days), Oct. 21 & 22, 8:30 AM-5:00 PM; Oct. 23, 8:30 AM-12 Noon. Northwestern Memorial Hospital, Chicago. CME Credit: 17 hrs. AMA Cat. 1. Fee: \$150. Reg. Limit: 100. Reg. Deadline: October 21. Sponsor, contact: Northwestern University Cancer Center, Northwestern University Medical School, 303 E. Chicago Avenue, Chicago 60611. Attn: John S. Schweppe, M.D., Chairman, Cancer Center Education Committee. Telephone: (312) 649-8674 or 642-9294.

### Otolaryngology

#### ANNUAL OTOLARYNGOLOGIC ASSEMBLY

For: Physicians in specialty. Assembly-1 week. October 16-22, 8:00 AM-5:00 PM. University of Illinois, Eye and Ear Infirmary, Chicago. Speaker: Emanuel M. Skolnik, M.D., Chairman of the Assembly. CME Credit: 42 hrs. AMA Cat. 2. Sponsor, contact: Dept. of Otolaryngology, University of Illinois, 1855 W. Taylor Ave., Chicago 60612. Attn: Mrs. Evelyn Seman. Telephone: (312) 996-6582.

### Perinatal Medicine

#### SYMPOSIUM ON PERINATAL MEDICINE—CLINICAL AND BIOCHEMICAL ASPECTS

For: Pediatricians, Obstetricians, Gynecologists, Researchers, Medical Students, Nurses. Two-day Symposium. October 25 & 26, 8:30 AM-5:15 PM. Christ Hospital, Oak Lawn. Speakers: Nationally/Internationally known figures in Perinatal Medicine. Fee: \$50. Reg. Limit: 300. Reg. Deadline: Sept. 15. Sponsor, contact: Christ Hospital, 4440 West 95th St., Oak Lawn, IL 60453. Telephone: (312) 425-8000 ext. 5690. Attn: Dr. M. Rath or Dr. S. Kumar. Co-sponsor: Mead Johnson Laboratories.

### Psychiatry

#### GENESIS OF THE THERAPIST'S SELF: ITS IMPACT ON PATIENTS AND PEERS

For: Professionals and students in the health field. Lecture Series. October 6, November 3, January 12, February 2, March 2, and April 13. Forest Hospital, Des Plaines. CME Credit: 2 hrs. per lecture AMA Cat. 1. Fee: Series, \$90; Each lecture, \$15. Reg. Deadline: Entire Series before Oct. 6. Sponsor, contact: Leo Jacobs, M.D., Director of Medical Education, Forest Hospital & Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Telephone: (312) 827-8811.

### Varied—Multidisciplinary

#### CARLE FOUNDATION DAY

For: General Practitioners. Lecture Series and Evening Guest Speaker. October 27, Ramada Inn, Champaign, Illinois. Fee: None. Sponsor, contact: Carle Foundation and Carle Clinic, Dept. of Neurology, 61 W. University Ave., Urbana, IL 61801. Attn: James B. Worrell, M.D. Telephone: (217) 337-3180.

## November, 1976

### Anesthesiology

#### REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING

For: All physicians. 5-day course, November 15-19. Chicago. CME Credit: 40 hrs. AMA Cat. 1. Fee: \$30. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Eugene Meyer. Telephone: (312) 733-2800.

### Diabetes Mellitus

#### NEW HORIZONS, 1976

For: Physicians and allied health professionals. One-day symposium. November 21, 9:00 AM-3:15 PM. Pick-Congress Hotel, Chicago. Main Speaker: Dr. Donald F. Steiner. Fee: \$15 for physicians not members of American Diabetes; \$10 for allied health prof. not members. Reg. Deadline: Nov. 18. CME Credit: 6 hrs. AMA Cat. 1. Sponsor, contact: American Diabetes Association, Greater Chicago and Northern Illinois Affiliate, 620 N. Michigan Ave., Chicago IL 60611. Attn: Florence Narodick. Telephone: (312) 943-8668.

### Early Breast Cancer Detection Methods

#### 2ND MID AMERICAN BREAST CANCER SYMPOSIUM

For: Physicians. Symposium. Nov. 5-6, 8:30 AM-5:30 PM. Concourse Hotel, Madison, Wisconsin. Speaker: Dr. Robert Egan. CME Credit: 12 hrs. AMA Cat. 2. Fee: \$75. Reg. Limit: 300. Reg. Deadline: Oct. 15. Sponsor, contact: Wisconsin Breast Cancer Detection Foundation, Inc., 7803 Mineral Point Rd. Madison, Wisconsin 53717. Attn: Paula Hobbin. Telephone: (608) 831-2300. Co-sponsor: National Association for Cancer Detection.

### Marital Therapy (Divorce)

#### FOURTH ANNUAL FALL CONFERENCE: CREATIVE DIVORCE

For: Physicians and mental health professionals. Two-day workshop. November 11-12, 9:00 AM-4:30 PM. Norris Center, McCormick Auditorium, 1999 Sheridan Road, Evanston. Speaker: Mel Krantzler, M.S., Director, Creative Divorce Nat'l Counseling Center, San Rafael, CA. CME Credit: 14 hrs. AMA Cat. 1. Fee: \$70. Sponsor, contact: The Family Institute of Chicago Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

### Pediatric Neurology

#### CLINICAL ADVANCES IN PEDIATRIC NEUROLOGY

For: Pediatricians, Neurologists. 2-day continuing education course. November 8-9. Holiday Inn Central Milwaukee, Wisconsin. Speaker: Jerome V. Murphy, M.D. CME Credit: 12 hrs. AMA Cat. 1. Fee: \$125. Reg. Limit: 120. Sponsor, contact: Medical College of Wisconsin, Office of Continuing Education, 561 N. 15th St., Milwaukee, Wisconsin 53233. Attn: Edwin O. Hirsch, M.D. Telephone: (414) 272-5450, ext. 335.



Blue Cross®  
Blue Shield®



# REPORT

## FOR *Illinois Physicians*

### Medicare Supplemental Coverage

To help cover medical expenses of patients not paid in full by the Medicare program, Blue Cross and Blue Shield offers programs to supplement Medicare allowances. At age 65, Illinois Blue Cross-Blue Shield members are converted to Medicare supplemental coverage.

Because our Blue Shield Claims Department operates independently of the two Medicare Part B carriers in Illinois, a separate claim for supplemental benefits must be filed directly with Blue Shield. A Physician's Service Report should be completed the same way as for those members under 65, and should include a full description of service performed and the doctor's usual charge for each service. Services to patients may be reported before the Medicare claim is filed, at the same time, or afterwards.

Two types of coverage are offered:

- (1) *Blue Cross 65/Blue Shield 65* (CODE 6E):  
This is the standard supplemental to Medicare for group and direct-pay members.  
For Medicare Part B services, Blue Shield will pay 20% of doctors' Usual and Customary charges for:
  - In-hospital professional services of physicians
  - Physicians' visits to patients in Extended Care Facilities
  - Radiation therapy, including X-ray therapy or radioisotope therapy for cancer, wherever performed
  - Out-patient or office surgery, care of fractures and complete dislocations including the initial X-rays and accident care within 72 hours
  - Surgical assistance

If the member has not paid the physician's fee, the payment of 20% Usual and Customary charges for services covered under the Blue Shield 65 program will be made directly to the doctor after the Physician's Service Report is processed.

- (2) *Series 65 Group (group membership only):*

These programs are written to assure that the "over 65" member of a group, whether working or retired, will receive as much coverage between Medicare benefits and Blue Shield supplemental coverage as employees under 65 would receive from their basic certificates.

Under this plan, the amount payable by Medicare Part B for a covered service is deducted from what normally would have been paid under the group's basic certificate. The balance is the benefit paid by Blue Shield. In no instance will the program duplicate Medicare payments.

Because of the nature of the Series 65 Group program (i.e., relationship to the group's basic contract) claims cannot be processed without a copy of the Explanation of Medicare Benefits. This form is sent to the member after Medicare has adjudicated its claim. It is the responsibility of the member to supply a copy of this form to Blue Shield directly or through the physician's office.

Only with the Explanation of Medicare Benefits plus a completed Physician's Service Report can the eligible benefits of these programs be determined. When the basic coverage in the group is written at 100% of Usual and Customary charges, the supplemental coverage fills the Medicare gaps fully. Where basic group coverage allowances are less than the Medicare payment, no supplemental benefits are payable. There are a number of variations between these extremes and the application of Medicare's \$60 deductible becomes an important factor in determining whatever benefits are payable.

A Blue Shield Physician's Service Report form should always be completed and submitted to obtain benefits supplemental to Medicare Part B, regardless of the member's contract. A Service Report and completed SSA-1490 Request for Medicare Payment form may be submitted together, *but please do not staple them together* as they are routed to separate Claims Departments. Pre-printed Blue Shield claims envelopes are available for your convenience upon request.

(This report is a service to the physicians of Illinois)

## ASK BLUE SHIELD

### . . . ABOUT MEDICARE

## Notification of Changes in Certification of Laboratories

We have been notified by the Social Security Administration of changes in status of the following independent laboratories regarding their participation and certification in the Medicare program:

#### Approved for Participation in Medicare Program:

Bionic Medical Laboratory and X-ray, Inc., 1708 W. Chicago Avenue, Chicago 60622 (Provider Number 14-8316) has been approved for participation under the Medicare program to perform the following tests and procedures: Serology, Chemistry, Hematology, Diagnostic Cytology, Blood Grouping and Rh Typing. Effective date is March 19, 1976.

#### Reinstated for Portable X-ray Laboratory Services:

Portable Medical X-ray Service, 6132 South Kedzie Avenue, Chicago 60629 (Provider Number 14-9801) has been reinstated as a supplier of portable x-ray services under the Medicare program by the State Operations Branch, Bureau of Health Insurance, Social Security Administration, effective September 7, 1976.

#### Change in Ownership Through Incorporation:

G-2 Clinical Laboratory, 1908 St. Charles Road, Maywood 60153 (Provider Number 14-8294) has changed ownership through incorporation effective July 26, 1976. It is approved for the following tests and procedures under the Medicare program: Mycology, Parasitology, Serology, Chemistry, Hematology, Blood Grouping and Rh Typing, Diagnostic Cytology and EKG Services.

#### No Longer Meets Medicare Coverage Requirements:

E. B. Laboratory Service, 2656 W. 63rd Street, Chicago 60629 (Provider Number 14-8263) no longer meets the requirement of services under the Medicare program according to a Social Security Administration determination. Services are not reimbursable effective October 1, 1976.

#### Changes in Approved Specialties or Subspecialties:

Sommerfield Medical Laboratory, Inc., 5818 Dempster Street, Morton Grove 60053 (Provider Number 14-8067) is no longer approved by the Illinois Department of Public Health to perform the following procedures: 130-Parasitology, 220-Serology-Other, 330-Chemistry-Other, 510-Blood Grouping and Rh Typing and 710-EKG Services effective October 1, 1976. The laboratory is approved to perform Bacteriology, Syphilis, Routine Chemistry, Clinical Microscopy and Hematology.

Anatomic and Clinical Pathology, Ltd., 8931 Bell Avenue, Chicago 60620 (Provider Number 14-8004) is no longer approved by the Illinois Department of Public Health to perform Procedures 610-Tissue Pathology and 620-Oral Pathology effective October 1, 1976. The laboratory is approved to perform Diagnostic Cytology.

Austin Chemical Laboratory, 7830 W. North Avenue, Elmwood Park 60635 (Provider Number 14-8139) is no longer approved by the Illinois Department of Public Health to perform Procedure 330-Chemistry-Other. The laboratory is approved to perform procedures in Serology, Hematology and EKG Services.

Ninety-fifth Street X-ray and Clinical Laboratory, 243 West 95th Street, Chicago 60628 (Provider Number 14-8164) is no longer approved by the Illinois Department of Public Health to perform Procedure 330-Chemistry-Other, effective October 1, 1976. The laboratory is approved to perform Routine Chemistry, Clinical Microscopy, Hematology, EKG Services, Blood Grouping and Rh Typing, Serology.

Park DeWatt Laboratories, Inc., 111 N. Wabash Avenue, Chicago 60602 (Provider Number 14-8155) has ceased to perform Procedures 120-Mycology and 130-Parasitology the Illinois Department of Public Health advised, and the procedures have been deleted from the listing of their approved tests effective October 1, 1976. The laboratory is approved for Bacteriology, Serology, Chemistry, Hematology, and Pathology.

Madison Medical Laboratory, 5050 South State Street, Suite 211, Chicago 60609 (Provider Number 14-8248) is no longer approved by the Illinois Department of Public Health for Procedures 710-EKG Services effective October 1, 1976. The laboratory is approved to perform procedures in Parasitology, Chemistry, Blood Grouping, Rh Typing, Rh Titers, Bacteriology and Diagnostic Cytology.

Perla Quipse Laboratories, Inc., 648 E. 43rd Street, Chicago 60653 (Provider Number 14-8256) is no longer approved by the Illinois Department of Public Health to perform Procedure 130-Parasitology and 510-Blood Grouping and Rh Typing effective October 1, 1976. The laboratory is approved to perform procedures in Serology, Chemistry, Hematology, Diagnostic Cytology and EKG Services.



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for relief of  
mild to  
moderate pain

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propoxyphene napsylate with acetaminophen

**Indications:** For the relief of mild to moderate pain, either alone or accompanied by fever.

**Contraindications:** Hypersensitivity to propoxyphene or to acetaminophen.

**Warnings:** *Drug Dependence*—Propoxyphene can produce drug dependence characterized by psychic dependence and, less frequently, physical dependence and tolerance. Propoxyphene will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to that of codeine although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

*Usage in Ambulatory Patients*—Propoxyphene may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly.

*Usage in Pregnancy*—Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, propoxyphene should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

*Usage in Children*—Propoxyphene is not recommended for use in children, because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric age group.

**Precautions:** Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The central-nervous-system depressant effect of propoxyphene may be additive with that of other C.N.S. depressants, including alcohol.

**Adverse Reactions:** The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, lightheadedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances.

The chronic ingestion of propoxyphene in doses exceeding 800 mg. per day has caused toxic psychoses and convulsions.

[011375A]

Additional information available to the profession  
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## **Clinics for Crippled Children Listed for November**

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be seven special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- November 3 Hinsdale, Hinsdale Sanitarium
- November 4 Sterling, Community General Hospital
- November 4 Effingham, St. Anthony Hospital
- November 4 Springfield, St. John's Hospital
- November 4 Lake County Cardiac, Victory Memorial Hospital
- November 5 Chicago Heights Cardiac, St. James Hospital
- November 8 Peoria Cardiac, St. Francis Children's Hospital
- November 9 Peoria, St. Francis Children's Hospital
- November 9 E. St. Louis, Christian Welfare Hospital
- November 10 Elgin, Sherman Hospital
- November 10 Springfield Pediatric-Neurology, St. John's Hospital
- November 10 Joliet, St. Joseph's Hospital
- November 10 Champaign-Urbana, McKinley Hospital
- November 11 Macomb, McDonough District Hospital
- November 11 DuQuoin, Marshall Browning Hospital
- November 12 Division Cardiac, U. of Illinois Hospital, Center for Handicapped Children
- November 16 Rock Island, Moline Public Hospital
- November 16 Belleville, St. Elizabeth's Hospital
- November 16 Decatur, Decatur Memorial Hospital
- November 17 Rockford, St. Anthony Hospital
- November 17 Centralia, St. Mary's Hospital
- November 17 Evergreen Park, Little Company of Mary Hospital
- November 18 Pittsfield, Illini Hospital
- November 18 Elmhurst Cardiac, Memorial Hospital of DuPage County
- November 19 Chicago Heights Cardiac, St. James Hospital
- November 22 Peoria Cardiac, St. Francis Children's Hospital
- November 23 Peoria, St. Francis Children's Hospital
- November 23 Alton, Alton Memorial Hospital
- November 24, Chicago Heights, St. James Hospital
- November 24 Elgin, Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on behalf of crippled children.

# *Abstracts of Board Actions*

August 21-22, 1976

Chicago

## **Liaison Committee to Clarify Peer Review Channels**

The Board of Trustees directed the ISMS/IFMC Liaison Committee to develop clear peer review channels for organized medicine with respect to the Medicaid program. The Board noted the extreme difficulty in sorting out the Society's responsibilities for responding to requests for medical evaluation of the practices being followed by physicians under the Medicaid program while, at the same time, the Illinois Department of Public Aid is conducting administrative audits which may eventually lead to legal action to recover improper payments to physicians, prosecution for fraud, removal from the program or other disciplinary measures. The Board noted further confusion through the 3-way involvement of the IDPA Medical Advisory Committee (a Committee of the Department involving ISMS members but not appointed by ISMS), the Illinois Foundation for Medical Care through its negotiating assignment from the House of Delegates and the county and state peer review channels established under the ISMS Bylaws. The Board wants the entire process studied and adequate procedures established which will identify physicians guilty of wrong-doing but will also protect those physicians who are not guilty of wrong-doing and who are being denied "due-process" under the IDPA audit procedures. The Liaison Committee also has been asked to clarify the appropriate relationship between physicians and laboratories which lease space in group practice facilities.

## **Dues Delinquent Members**

Some 405 physicians who paid their regular 1976 medical society dues—but failed to pay the \$75.00 assessment voted by the House of Delegates last November—have automatically been dropped from membership effective June 30 as per bylaws requirements. These former members were not reported to the AMA since their state medical society membership was never perfected by the full payment of dues. The Board acted to direct that all ISMS and AMA dues money paid by these physicians in 1976 be returned to their component societies and the physicians so informed. Former members in this category can reinstate their membership only by paying their full dues plus the assessment for 1976.

## **Physician's Assistants**

An Advisory Committee to Physician's Assistants will be established under the Council on Education and Manpower to: (1) Make recommendations for improvement in the Physician Assistant Act and its regulations; (2) Determine how this new category of health care personnel can best be utilized; and (3) Establish liaison with existing physician's assistants organizations.

## **House of Delegates**

The first interim session of the ISMS House of Delegates will open at 10 a.m. Saturday, Nov. 6, at the Continental Regency Hotel in Peoria. The second and final session will start at 9 a.m. Sunday. Deadline for resolutions to be printed in the Illinois Medical Journal is September 4; final deadline for resolutions is October 9.

The Board approved the following dates for future annual meetings of the House of Delegates: April 1-5, 1978, and May 5-9, 1979, at the Palmer House in Chicago.

The 1977 annual meeting is scheduled for April 24-27 at the Holiday Inn Mart Plaza in Chicago.

*(Continued on page 438)*

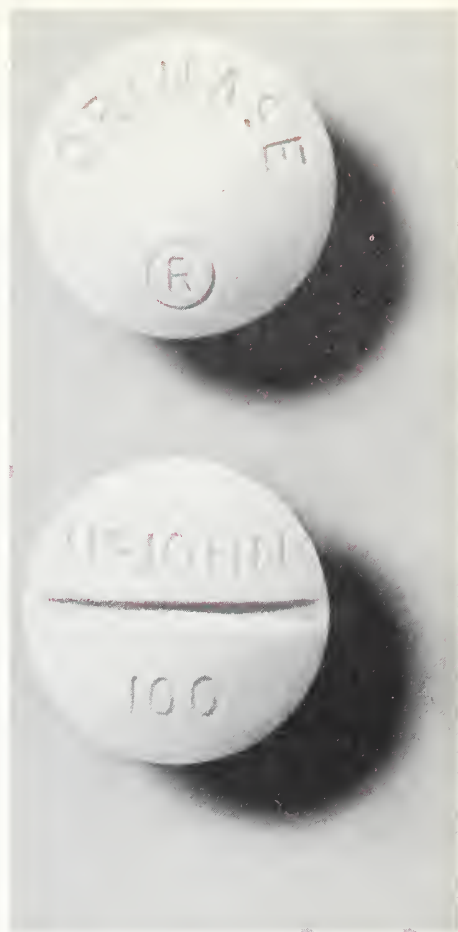


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# Editorials



## Need for Modification

Many suggestions to modify the American diet have been made during the last decade. Those most frequently mentioned aim toward the prevention of major causes of death and disability, including coronary disease, diabetes, colonic cancer and diverticulitis. However, dietary habits are fundamentally cultural, and, as such, are highly resistant to change.

The relationship between diet and hypercholesterolemia is well known. Menus low in saturated fats and cholesterol will lower the blood lipid levels, but the patient is often unable to feel these changes. Not only does the patient experience no tangible improvement, but no physician can guarantee that lowering the level will forestall a heart attack or stroke. In addition, endless debate regarding the details of the diet often adds to the patient's confusion.

We might add that hypercholesterolemia is not always of dietary origin. It is frequently associated with diabetes and hypothyroidism.

Evidence has grown to support a possible relationship between dietary fiber and diseases of the colon. Dr. D. P. Burkett of England and others reported that certain diseases of the large intestine are less common in countries where the diet is high in food fiber. Their evidence was mainly epidemiological.

The rationale of the Burkett theory is based upon evidence that Blacks in Africa, who eat

considerable roughage, have a low incidence of colonic cancer and diverticulitis, and, barring other causes, diet must be given credit.

Further indirect evidence supports this concept. Bulkier feces could increase the diameter of the colon and prevent sudden rises in pressure which are believed to cause diverticulum. Softer foodstuffs take more time to pass through the bowel, which allows them longer contact with carcinogens. As a result, those who partake of diets low in fiber are more likely to develop diseases of the bowel than are those eating whole wheat cereals (bran), breads, root vegetables and raw fruits.

This, too, can be confusing. All physicians have patients who swear they develop a recurrence of diverticulitis when their roughage intake is increased. Some of them now find that they can tolerate bran, root vegetables and fresh fruits.

Unfortunately, H.E.W. does not insist on double blind controlled studies on new dietary treatments, as they do with drugs. This aspect of nutrition is less easily adapted to scientific evaluation and lengthier study is usually required to determine effectiveness.

T. R. Van Dellen, M.D., *Editor*



## Guest Editorial

# The Illinois Congress on CME

*In 1972, ISMS invited the State's eight medical schools to join in a unique co-operative venture between profession and professional school—the Illinois Council on Continuing Medical Education. ICCME has worked quietly but effectively throughout the state since that time. To insure that all ISMS members know about ICCME services, we have arranged for members of that Council's Board to write a series of editorial reports. This is the eighth in that series.*

The function and goals of ICCME are in some ways difficult to define. To clarify and simplify this definition, an analogy could be made to the functions of an Estate Planning Consultant.

An Estate Planner has basically three principal functions to perform for his client:

1. *Sales.* He must convince his potential client that he indeed needs an estate plan.

2. *Counselor and Advisor.* He must help his client to analyze short-term and long-term needs, and then recommend a coordinated plan which will satisfy these needs. Such needs would be the desire to build up his assets, protection of these assets, and provide for transition of these assets to his beneficiaries. Thus a savings and investment program, an insurance program, and a will and suitable living trust agreements, would be proposed.

3. *Broker.* He must arrange contacts where necessary with qualified providers of the various services recommended in the Estate Plan. Implicit in this third function as a broker in his investigation and monitoring of the activities of these providers so as to assure his client that he is receiving quality services.

As a corollary to his second function as Counselor and Advisor, he must periodically review the program to see that current needs are met, and to suggest revisions as the client's needs may change.

The functions of ICCME and its annual Congress may be expressed along the same lines as the Estate Planner in this analogy. Our client is the Illinois physician.

### I. Sales

In our consumer-oriented society, more and more pressure is being applied for the physician to provide quality care. Pressures from *without*

(consumer groups and federal and state legislatures) and from *within* the medical profession are forcing the insistence that the individual physician pursue some form of continuing medical education. Thus our first function—*sales*—is partially performed for us. However, we must certainly provide the mechanism by which this need for CME can be recognized by our client, the Illinois physician, as it applies to his own particular medical practice.

Much effort to date has been expended along this line, and our First Congress on CME essentially addressed itself to this function.

### II. Counselor and Advisor

Means to facilitate *self-analysis* of the individual physician's needs have been provided. Such means are exemplified by the various self-assessment exams formulated by many of the specialty societies. More applicable to the broad spectrum of our clientele is "Your Personal Learning Plan," authored by Leonard Stein, Ph.D., and published by ICCME.

More practical is the analysis of one's medical practice within a hospital setting by the Medical Care Evaluation mechanism—or a similar review under whatever name which accomplishes the same objective. Such medical care evaluation can point up the possible short-comings of the entire hospital staff as well as of the individual physician, and indicate along what lines an educational program should be planned.

Such needs-analysis has also been the subject of much of our Council's efforts in the past two years and was the main theme of our Second Congress on CME. The ICCME Accreditation questionnaire, and the Hospital CME Consultation Service facilitate this needs-analysis.

(Continued on page 444)

# Pain: a call to action.



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Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.



\*See dosage and administration section of Brief Summary

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**DESCRIPTION** Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

**INDICATIONS** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS** Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

**WARNINGS Drug Dependence** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCODAN<sup>®</sup>, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCODAN<sup>®</sup> is subject to the Federal Controlled Substances Act.

**Usage in ambulatory patients** Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCODAN<sup>®</sup> should be cautioned accordingly.

**Interaction with other central nervous system depressants** Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCODAN<sup>®</sup> may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

**Usage in pregnancy** Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCODAN<sup>®</sup> should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

**Usage in children** PERCODAN<sup>®</sup> should not be administered to children. PERCODAN<sup>®</sup>-Demi, containing half the amount of oxycodone, can be considered. (See product prescribing information for PERCODAN<sup>®</sup>-Demi.)

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

#### PRECAUTIONS Head injury and increased intracranial pressure

The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute abdominal conditions** The administration of PERCODAN<sup>®</sup> or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

**Special risk patients** PERCODAN<sup>®</sup> should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

**ADVERSE REACTIONS** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation and pruritus.

**DOSE AND ADMINISTRATION** Dosage should be adjusted according to the severity of the pain and the response of the patient. It may be occasionally necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCODAN<sup>®</sup> is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

**DRUG INTERACTIONS** The CNS depressant effects of PERCODAN<sup>®</sup> may be additive with that of other CNS depressants. See WARNINGS.

Aspirin may enhance the effect of anticoagulants and inhibit the uricosuric effect of uricosuric agents.

**MANAGEMENT OF OVERDOSE Signs and Symptoms** Serious overdose with PERCODAN<sup>®</sup> is characterized by respiratory

depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence, progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. Severe overdosage, apnea, circulatory collapse, cardiac arrest, death may occur. The ingestion of very large amounts of PERCODAN<sup>®</sup> may, in addition, result in acute salicylate intoxication.

**Treatment** Primary attention should be given to the re-establishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine or levallorphan specific antidotes against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including oxycodone. Therefore, an appropriate dose of one of these antagonists should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of oxycodone may exceed that of antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated.

Gastric emptying may be useful in removing unabsorbed drug. **DEA Order Form Required.**

PERCODAN<sup>®</sup> is a registered trademark of Endo, Inc.

**Endo Inc.**  
 Manati, Puerto Rico 00701  
 Subsidiary of E. I. du Pont de Nemours & Co. (I)



## Obituaries

**Axtel, Samuel**, Lake Bloomington, died August 16th in Bloomington. Dr. Axtel was a graduate of Illinois State University. He was an intern and resident at the Chicago School of Osteopathy. Dr. Axtel practiced in Lexington from 1924-1973.

**\*Carter, Robert L.**, Earlville, died August 8th at the age of 37. Dr. Carter was a 1966 graduate of the University of Illinois Medical School.

**\*Changus, George W.**, Chicago, died on July 23rd at the age of 63. He was the retired director of Pathology and laboratories at Mercy Hospital. Dr. Changus graduated from St. Louis University in 1943.

**Chapman, Bess**, Rock Island. Mrs. Chapman, wife of Dr. W. B. Chapman, deceased secretary of ISMS 1923-1924, was county president in the Rock Island County Chapter of the ISMS Auxiliary, and state president of the Auxiliary in 1935-1936.

**\*Chesley, George L.**, Bloomington, expired July 7, at the age of 60. Dr. Chesley was a 1943 graduate of Northwestern University and a member of the McLean County Medical Society.

**\*Clark, E. L.**, Shelbyville, died on July 23rd at the age of 78. Dr. Clark practiced in Shelbyville until 1938 and retired in Bradenton, Florida. He was a 1927 graduate of the Chicago Medical School.

**\*Copeland, William J.**, Cary, died on August 17 at the age of 71 in Elgin, Illinois. Dr. Copeland was a 1933 graduate of Illinois.

**\*Ditkowsky, Samuel Irwin**, Chicago, died August 8th at the age of 69. Dr. Ditkowsky was a 1933 graduate of the University of Illinois.

**\*Dreyfuss, Ernest Heinrich**, Chicago, died August 7 at the age of 66. Dr. Dreyfuss was a 1935 graduate of University di Firenze, Italy.

**\*Eilert, William G.**, Aurora, passed away July 2nd at the age of 68. Dr. Eilert was a 1935 graduate of Northwestern University.

**\*\*Fishbein, Morris**, Chicago, passed away at the age of 87. Dr. Fishbein was the editor of the Journal of the American Medical Association (JAMA) from 1924 to 1949. He was also a past president of the Chicago Medical Society and the Chicago Heart Association. Two of his finer legacies were the Morris Fishbein Institute for Forensic Medicine at the Cook County Morgue and the Morris Fishbein Center for the study of the history of science and medicine at the University of Chicago. Dr. Fishbein had worked with such men as Dr.'s Frank Billings, Ludvig Hektoen, and James B. Herrick. He was also a noted speaker, sometimes addressing 100 to 300 different group in one year. Morris Fishbein was born on July 22, 1889, in St. Louis. He attended the University of Chicago and Rush Medical College.

**\*Guy, Chester C.**, Chicago, expired on August 24th at the age of 77. Dr. Guy was a 1924 graduate of Rush Medical College.

**\*\*Hans, Edward**, Chicago, died August 8th at the age of 86. Dr. Hans was a 1916 graduate of the Chicago College of Medicine and Surgery (Loyola).

**\*Harp, Robert Allen**, 47, died August 18th. Dr. Harp was a cardiovascular surgeon and was elected president of the Illinois Heart Association in 1970. He was a 1954 graduate of the University of Texas and received his M.S. from the University of Minnesota in 1961.

**\*Kilikanis, Vytautas A.**, Evanston, expired August 25th at the age of 52. Dr. Kilikanis, an eye specialist and surgeon, was a 1949 graduate of Baden-Wurttemberg, Germany.

**\*Kimovec, Franc**, Wilmette, passed away August 19th at the age of 55. He was a 1952 graduate from Graz, Austria.

**\*Kositchek, Sol B.**, Wichita, Kansas, formerly of Chicago, died at the age of 90 on September 11th. After his graduation in 1909 from the University of Michigan at Ann Arbor Dr. Kositchek served on the staff of Grant Hospital for more than 50 years.

**\*Liepins, Kurts W.**, Crestwood, died at the age of 54 on August 18th. Dr. Liepins was a 1950 graduate of Lahn, Hessen, Germany.

**\*Massessa, Rocco A.**, Chicago, died on June 12. Dr. Massessa was a 1933 graduate of Northwestern University. He was 67 at the time of his death.

**\*Mathis, Alvin L.**, Oak Brook, passed away at the age of 80 on August 13. Dr. Mathis was an Elmhurst physician for 30 years. He graduated from the University of Illinois in 1930.

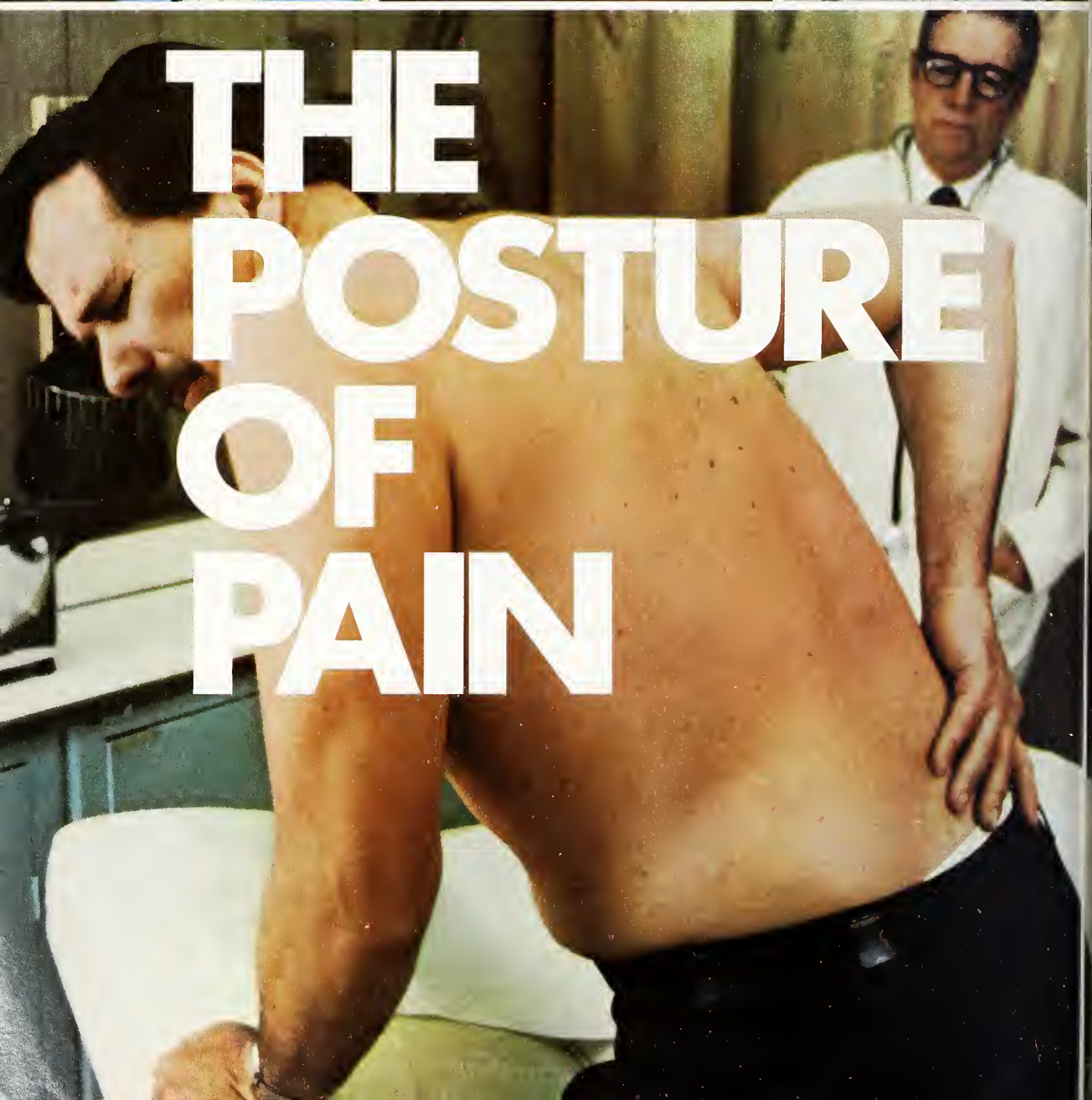
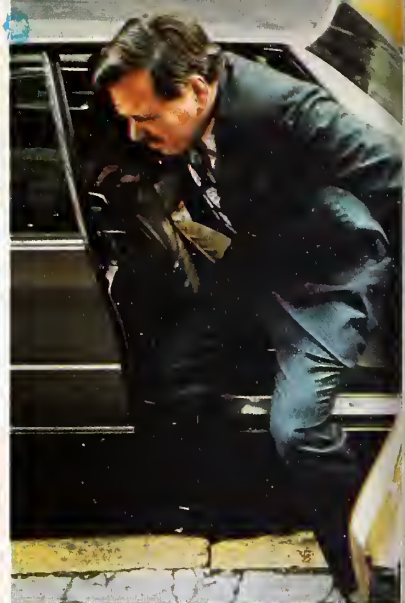
**\*Shapiro, Fred**, died August 5th at the age of 72. Dr. Shapiro was a 1931 graduate of the University of Illinois.

**\*Stevens, John W.**, DuQuoin, 69, passed away July 22nd. Dr. Stevens was a 1930 graduate of the University of Illinois.

**\*Vincenti, Louis A.**, Oak Park, died at the age of 66 on July 22. Dr. Vincenti was a prominent Oak Park physician for 44 years. He was a staff member of St. Elizabeth Hospital and a member of the Academy of Surgeons. Dr. Vincenti was a 1934 graduate of the Stritch School of Medicine, (Loyola).

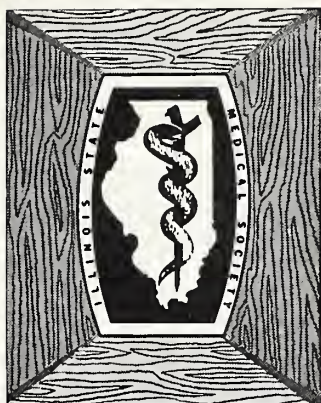
*\*Indicates ISMS member.*

*\*\*Indicates ISMS member and member of the Fifty Year Club.*



# THE POSTURE OF PAIN





# I M J

*Illinois Medical Journal*

Vol. 150, No. 4, October, 1976

## ISMS ORGANIZATION

### History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in

book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen is the editor today.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922 he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

# OFFICERS AND PLACES OF MEETING

YEAR	PRESIDENT	SECRETARY	TREASURER	MTG. PLACE	YEAR	PRESIDENT	SECRETARY	TREASURER	MTG. PLACE
1840	John Todd	David Prince		Springfield	1880	Ephraim Ingalls	N. S. Davis	J. H. Hollister	Belleville
1850	Rudolph Rouse	Edwin G. Meek		Springfield	1881	G. W. Jones	S. J. Jones	J. H. Hollister	Chicago
1850	William B. Herrick	Edwin G. Meek	Jno. Halderman	Springfield	1882	Robert Boal	S. J. Jones	J. H. Hollister	Quincy
1851	Samuel Thompson	H. Shoemaker	R. Rouse	Peoria	1883	A. T. Darrah	S. J. Jones	J. H. Hollister	Peoria
1852	Rudolph Rouse	E. S. Cooper	Edw. Dickenson	Jacksonville	1884	E. Andrews	S. J. Jones	Walter Hay	Chicago
1853	Daniel Brainerd	H. A. Johnson	A. B. Chambers	Chicago	1885	D. S. Booth	S. J. Jones	Walter Hay	Springfield
1854	C. N. Andrews	H. A. Johnson	N. S. Davis	LaSalle	1886	Wm. A. Byrd	S. J. Jones	Walter Hay	Bloomington
1855	N. S. Davis	E. Andrews	J. V. Z. Blaney	Bloomington	1887	Wm. T. Kirk	D. W. Graham	Walter Hay	Chicago
1856	H. Noble	N. S. Davis	J. V. Z. Blaney	Vandalia	1888	Wm. O. Ensign	D. W. Graham	Walter Hay	Rock Island
1857	C. Goodbreak	H. A. Johnson	J. V. Z. Blaney	Chicago	1889	C. W. Earle	D. W. Graham	T. W. McIlwaine	Jacksonville
1858	H. A. Johnson	N. S. Davis	J. W. Freer	Rockford	1889	John Wright	D. W. Graham	T. W. McIlwaine	Chicago
1859	David Prince	N. S. Davis	J. W. Freer	Decatur	1891	Jno. P. Mathews	D. W. Graham	Geo. N. Kreider	Springfield
1860	Wm. M. Chambers	N. S. Davis	J. W. Freer	Paris	1892	Charles C. Hunt	D. W. Graham	Geo. N. Kreider	Vandalia
1863	A. McFarland	N. S. Davis	J. H. Hollister	Jacksonville	1893	E. Fletcher Ingalls	D. W. Graham	Geo. N. Kreider	Chicago
1864	A. H. Luce	N. S. Davis	J. H. Hollister	Chicago	1894	Otho B. Will	J. B. Hamilton	Geo. N. Kreider	Decatur
1865	J. M. Steele	N. S. Davis	J. H. Hollister	Bloomington	1895	Daniel R. Brower	J. B. Hamilton	Geo. N. Kreider	Springfield
1866	F. F. Haller	N. S. Davis	J. H. Hollister	Decatur	1896	D. W. Graham	J. B. Hamilton	Geo. N. Kreider	Ottawa
1867	H. Noble	N. S. Davis	J. H. Hollister	Springfield	1897	A. C. Corr	J. B. Hamilton	Geo. N. Kreider	East St. Louis
1868	S. T. Trowbridge	N. S. Davis	J. H. Hollister	Quincy	1898	J. N. G. Carter	E. W. Weis	Geo. N. Kreider	Galesburg
1869	S. T. Trowbridge	T. D. Fitch	J. H. Hollister	Chicago	1899	J. T. Pitner	E. W. Weis	Geo. N. Kreider	Cairo
1870	J. V. Z. Blaney	T. D. Fitch	J. H. Hollister	Dixon	1900	H. N. Moyer	E. W. Weis	Geo. N. Kreider	Springfield
1871	G. W. Albin	T. D. Fitch	J. H. Hollister	Peoria	1901	G. N. Kreider	E. W. Weis	E. J. Brown	Peoria
1872	J. O. Hamilton	T. D. Fitch	J. H. Hollister	Rock Island	1902	J. T. McAnally	E. W. Weis	E. J. Brown	Quincy
1873	D. W. Young	T. D. Fitch	J. H. Hollister	Bloomington	1903	M. L. Harris	E. W. Weis	E. J. Brown	Chicago
1874	T. F. Worrell	T. D. Fitch	J. H. Hollister	Chicago	1904	C. E. Black	E. W. Weis	E. J. Brown	Bloomington
1875	J. H. Hollister	T. D. Fitch	Wm. E. Quine	Jacksonville	1905	W. E. Quine	E. W. Weis	E. J. Brown	Rock Island
1876	T. D. Washburn	N. S. Davis	J. H. Hollister	Urbana	1906	H. C. Mitchell	E. W. Weis	E. J. Brown	Springfield
1877	T. D. Fitch	N. S. Davis	J. H. Hollister	Chicago	1907	J. F. Percy	E. W. Weis	E. J. Brown	Rockford
1878	J. L. White	N. S. Davis	J. H. Hollister	Springfield	1908	W. L. Baum	E. W. Weis	E. J. Brown	Peoria
1879	E. P. Cook	N. S. Davis	J. H. Hollister	Lincoln	1909	J. W. Pettit	E. W. Weis	E. J. Brown	Quincy



YEAR	PRESIDENT	SECRETARY	TREASURER	MTG. PLACE	YEAR	PRESIDENT	SECRETARY	TREASURER	MTG. PLACE
1910	J. L. Wiggins	E. W. Weis	E. J. Brown	Danville	1944	G. W. Post**	H. M. Camp	H. M. Camp	Chicago
1911	A. C. Cotton	E. W. Weis	E. J. Brown	Aurora	1945	E. P. Coleman	H. M. Camp	H. M. Camp	***
1912	W. K. Newcomb	E. W. Weis	E. J. Brown	Springfield	1946	E. P. Coleman	H. M. Camp	H. M. Camp	Chicago
1913	L. H. A. Nickerson	E. W. Weis	A. J. Markley	Peoria	1947	R. S. Berghoff	H. M. Camp	H. M. Camp	Chicago
1914	Charles J. Whalen	W. H. Gilmore	A. J. Markley	Decatur	1948	I. H. Neece	H. M. Camp	H. M. Camp	Chicago
1915	A. L. Brittain	W. H. Gilmore	A. J. Markley	Springfield	1949	Percy E. Hopkins	H. M. Camp	H. M. Camp	Chicago
1916	C. W. Lillie	W. H. Gilmore	A. J. Markley	Champaign	1950	Walter Stevenson	H. M. Camp	H. M. Camp	Springfield
1917	W. L. Noble	W. H. Gilmore	A. J. Markley	Bloomington	1951	Harry M. Hedge	H. M. Camp	H. M. Camp	Chicago
1918	E. B. Coolley	W. H. Gilmore	A. J. Markley	Springfield	1952	C. Paul White	H. M. Camp	H. M. Camp	Chicago
1919	E. W. Eiegenbaum	W. H. Gilmore	A. J. Markley	Peoria	1953	Leo P. A. Sweeney	H. M. Camp	H. M. Camp	Chicago
1920	J. W. Van Derslice	W. H. Gilmore	A. J. Markley	Rockford	1954	Willis I. Lewis	H. M. Camp	H. M. Camp	Chicago
1921	W. F. Grinstead	W. H. Gilmore	A. J. Markley	Springfield	1955	Arkell M. Vaughn	H. M. Camp	H. M. Camp	Chicago
1922	Charles Humiston	W. H. Gilmore	A. J. Markley	Chicago	1956	F. Garm Norbury	H. M. Camp	H. M. Camp	Chicago
1923	E. P. Sloan	W. D. Chapman	A. J. Markley	Decatur	1957	F. Lee Stone	H. M. Camp	H. M. Camp	Chicago
1924	E. H. Ochsner	W. D. Chapman	A. J. Markley	Springfield	1958	Lester S. Reavley	H. M. Camp	H. M. Camp	Chicago
1925	L. C. Taylor	H. M. Camp	A. J. Markley	Quincy	1959	Raleigh C. Oldfield	H. M. Camp	H. M. Camp	Chicago
1926	J. C. Krafft	H. M. Camp	A. J. Markley	Champaign	1960	Joseph T. O'Neill	George F. Lull	George F. Lull	Chicago
1927	Mather Pfeifferberger	H. M. Camp	A. J. Markley	Moline	1961	H. Close Hesselstine	Jacob E. Reisch	Jacob E. Reisch	Chicago
1928	G. Henry Mundt	H. M. Camp	A. J. Markley	Chicago	1962	Edwin S. Hamilton	Jacob E. Reisch	Jacob E. Reisch	Chicago
1929	J. E. Tuite	H. M. Camp	A. J. Markley	Peoria	1963	George F. Lull	Jacob E. Reisch	Jacob E. Reisch	Chicago
1930	F. O. Frederickson	H. M. Camp	A. J. Markley	Joliet	1964	Harlan English	Jacob E. Reisch	Jacob E. Reisch	Chicago
1931	Wm. D. Chapman	H. M. Camp	A. J. Markley	East St. Louis	1965	Edward A. Piszczek	Jacob E. Reisch	Jacob E. Reisch	Chicago
1932	R. R. Ferguson	H. M. Camp	A. J. Markley	Springfield	1966	Burtis E. Montgomery	Jacob E. Reisch	Jacob E. Reisch	Chicago
1933	John R. Neal	H. M. Camp	A. J. Markley	Peoria	1967	Caesar Portes	Jacob E. Reisch	Jacob E. Reisch	Chicago
1934	Philip H. Kreuscher	H. M. Camp	A. J. Markley	Springfield	1968	Newton DuPuy	Jacob E. Reisch	Jacob E. Reisch	Chicago
1935	Charles D. Center*	H. M. Camp	A. J. Markley	Springfield	1969	Philip G. Thomsen	Jacob E. Reisch	Jacob E. Reisch	Chicago
1935	Charles S. Skaggs	H. M. Camp	A. J. Markley	Rockford	1970	Edward W. Cannady	Jacob E. Reisch	Jacob E. Reisch	Chicago
1936	Chas. B. Reed	H. M. Camp	A. J. Markley	Springfield	1971	J. Ernest Breed	Jacob E. Reisch	Jacob E. Reisch	Chicago
1937	Roland L. Green	H. M. Camp	A. J. Markley	Peoria	1972	L. T. Fruin****	Jacob E. Reisch	Jacob E. Reisch	Chicago
1938	R. K. Packard	H. M. Camp	A. J. Markley	Springfield	1973	Frank J. Jirka, Jr.	Jacob E. Reisch	Jacob E. Reisch	Chicago
1939	S. E. Munson	H. M. Camp	A. J. Markley	Rockford	1974	Willard C. Scrivner	Jacob E. Reisch	Jacob E. Reisch	Chicago
1940	Jas. H. Hutton	H. M. Camp	A. J. Markley	Peoria	1975	Fredric D. Lake	Jacob E. Reisch	Jacob E. Reisch	Chicago
1941	J. S. Templeton	H. M. Camp	A. J. Markley	Chicago	1976	J. M. Ingalls	Jacob E. Reisch	Jacob E. Reisch	Chicago†
1942	Chas. H. Phifer	H. M. Camp	H. M. Camp	Springfield	1977	Joseph H. Skom	Jacob E. Reisch	Jacob E. Reisch	Chicago
1943	E. H. Weld	H. M. Camp	H. M. Camp	Chicago					

\*Died before induction into office

\*\*Died in office. Term completed by Robert S. Berghoff, First Vice President

\*\*\*Meeting cancelled 1945

\*\*\*\*Died in office. Term completed by G. J. Jannings, First Vice President

†Interim sessions begun 1976, first scheduled in Peoria.

# Principles Of Medical Ethics

**PREAMBLE:** These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

**SECTION 1—**The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

**SECTION 2—**Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

**SECTION 3—**A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

**SECTION 4—**The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

**SECTION 5—**A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving

adequate notice. He should not solicit patients.

**SECTION 6—**A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

**SECTION 7—**In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

**SECTION 8—**A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

**SECTION 9—**A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

**SECTION 10—**The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.



# ILLINOIS STATE MEDICAL SOCIETY

## Constitution And Bylaws

Adopted, 1903  
As Amended, 1976

### CONSTITUTION

#### ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

#### ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

#### ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

#### ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

#### ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

#### ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, nineteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

#### ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

#### ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

#### ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

#### ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

### BYLAWS

#### CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Associate members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principal-

ly in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

- B. *Associate Members.* Associate members are physicians who hold the degree of Doctor of Medicine, who have a hospital permit to practice medicine in the State of Illinois and are members of their component medical society.
- C. *Emeritus Members.* Emeritus members are those who have been regular members in good standing for thirty-five years, have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application to their component society and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.
- D. *Retired Members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.
- E. *Service Members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.
- F. *Distinguished Members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.
- G. *In-Training Members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.
- H. *Student Members.* Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. *Discrimination of Membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

### Section 3. *Tenure and Termination.*

- A. *Tenure of Membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.
- B. *Termination of Membership.* Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of this society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Non-payment of dues by May 1 of each year shall be grounds for termination of membership.

## CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, Associate, In-training and Student members shall be assessed annual dues. The assessment shall be paid by the component society for its members prior to March 31 of each year.

Section 2. *Reduction and Remission of Dues.* Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments and Funds.* In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

## CHAPTER III. EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.



## CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies and affiliated groups, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, and 7) Trustees. Past trustees, past presidents, past speakers, general officers of the American Medical Association, and delegates and alternate delegates from the Illinois State Medical Society to the American Medical Association may have the privilege of the floor without vote.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* The student members of the Illinois State Medical Society shall be considered a single affiliate group and shall be entitled to elect from their group, one student delegate with vote and one student alternate delegate to serve in the House of Delegates. One intern/resident delegate with vote and an alternate delegate, representing the interests of Illinois house staff, shall be nominated by the Advisory Committee to Physicians in Training pursuant to appointment by the Board of Trustees. Each delegate shall be considered as an Affiliated Group Member of the Illinois State Medical Society. The term of office shall begin January first following his election and shall be for two years, or until his successor is elected.

Section 4. *Time and Place of Meeting.* The House of Delegates shall meet twice each year. These two meetings shall be designated as the annual meeting and the interim meeting. The time and place of both shall be as the House determines, except that the interim meeting should not exceed three days and it should be held in a district other than where the annual meeting is held.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolutions to be printed in the handbook must be submitted nine weeks prior to the annual meeting. Resolutions to be mailed to the delegates prior to the annual meeting must be submitted to ISMS headquarters four weeks prior to the annual meeting. Resolutions submitted after the above date must be approved by the Speaker, Vice Speaker and one delegate from CMS and one from outside CMS or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Reports of committees, councils and officers requiring action must submit recommendations to the House as a resolution for action. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

## CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, nineteen trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

**Section 3. *Terms of Office.*** The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

#### CHAPTER VI. DUTIES OF OFFICERS

**Section 1. *The President.*** The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

**Section 2. *The President-Elect.*** The President-Elect shall serve as the chairman of the Committee on Planning and Priorities.

**Section 3. *The Vice Presidents.*** The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

**Section 4. *Successor to President-Elect.*** In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

**Section 5. *The Speaker.*** The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

**Section 6. *The Vice Speaker.*** The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

**Section 7. *The Secretary-Treasurer.*** In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

**Section 8. *Delegates and Alternate Delegates to the American Medical Association.*** Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

#### CHAPTER VII. THE BOARD OF TRUSTEES

**Section 1. *Composition.*** The Board of Trustees shall consist of: nineteen trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in the absence of the chairman, shall serve as an ex-officio member of the Board of Trustees without vote. Nine trustees shall be chosen from District 3 and one from each of the other ten districts.

Region 1A (comprising the counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside and Winnebago) shall be entitled to one trustee for the two-year trial period approved in Resolution 75A-45 as passed by the House of Delegates on April 5, 1975. During this period, District 3 shall be entitled to an additional trustee.

During this two-year period, the Board of Trustees shall consist of twenty-one trustees.

**Section 2. *Duties.*** The duties of the Board of Trustees are executive, custodial and judicial.

**A. *Executive Duties.*** The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from



any committee in the interim between meetings of the House of Delegates.

- B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

- C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

- A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily

assume the responsibilities of the Chairman of the Board in the latter's absence.

- B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Ten members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

#### CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

#### CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

- A. Councils (standing committees)
- B. House of Delegates Committees
- C. Board of Trustees Committees
- D. Ethical Relations Committee (Chapter XI of these Bylaws)

##### Section 2. *Councils.*

A. The Medical-Legal Council shall be concerned in the areas of:

1. Liaison with the Illinois Bar Association
2. Liaison with courts, particularly where impartial medical testimony is involved.
3. Implementation of the Impartial Medical Testimony Rule
4. Legal aspects of medical practice other than in the area of mental health
5. Licensing and standards of practice.
6. Quackery
7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:

1. Federal and state legislation—analysis and communication

2. Legislative liaison—both state and federal
3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:

1. Liaison with medical schools, curricula, etc.
2. Health manpower and training
3. Internships, residencies, etc.
4. Scientific assembly
5. Student loans
6. Liaison with American Student Medical Association
7. Continuing Medical Education

D. The Council on Economics and Peer Review shall be concerned in the areas of:

1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
2. Relations with prepayment, insurance and other third party plans.
3. Fees and fee adjudication
4. Health care cost and utilization
5. Peer Review (Part 2 of Chapter XII of these Bylaws)

E. The Council on Environmental and Community Health shall be concerned in the areas of:

1. Governmental Departments of Health
2. Public Safety
3. Occupational Health
4. Child and School Health
5. Pollution
6. Nutrition
7. Maternal Welfare

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:

1. Publicity and promotion
2. News media relations
3. Exhibits and public service programming
4. Religion and medicine
5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:

1. Facilities and services
2. Liaison with Department of Mental Health
3. Legal aspects of commitment, etc.
4. Narcotics and dangerous drugs
5. Alcoholism

H. The Council on Social and Medical Services shall be concerned in the areas of:

1. Health care facilities and services
2. Emergency and disaster care
3. Liaison with other health professional and health oriented organizations
4. Health care of the poor
5. Problems of aging
6. Rural health

I. The Council on Affiliate Societies shall be concerned in the areas of:

1. Liaison between the affiliate society and ISMS.
2. Scientific resource information and advice to ISMS.
3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation.
4. Advances of medical science in special fields.



J. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as the chairman of the committee.

### Section 3. Organization of Councils.

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by Illinois Chapters of the American Student Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with the permission of the House of Delegates) the right to speak on the floor of the House, but to have no vote out of committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

### J. Affiliate Societies

1. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois

- a) as may be approved by the Board of Trustees
- b) which desire representation on the Council on Affiliate Societies

2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 4. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

C. Committee on Tellers and Sergeants-at-Arms shall:

1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Con-

stitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

- E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.
- F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

#### Section 5. *Organization of House of Delegates Committees.*

- A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.  
Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.
- B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.
- C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

#### Section 6. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

- A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. The chairman of the Illinois

Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

- B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

- 1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
- 2. Keep the names of the beneficiaries confidential and known only to the committee;
- 3. Recommend the allotment for each recipient; and
- 4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

- C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.
- D. The Ethical Relations Committee shall be constituted and function as stipulated in Chapter XI, Discipline, Part 2, Illinois State Medical Society procedures.
- E. The Committee on Constitution and Bylaws shall consist of five members, the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

- 1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
- 2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
- 3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

- F. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall



be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

G. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 7. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 8. *Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

## CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this society no later than 120 days prior to annual meeting.

Section 10. Any component society which fails to pay its assessment or make the annual report required on or before March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that

in consequence of nonpayment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

## CHAPTER XI. DISCIPLINE

### PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

- A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or
- B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:
  1. of a gross misconduct as a physician, or
  2. of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Formal Written Charges Presented to the Illinois State Medical Society.* Formal, written charges received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the charged individual is a member or to the district Ethical Relations Committee in the event that the com-

ponent society does not have an Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

- A. A charged individual is presumed to be innocent until he has been proven guilty.
- B. No proceeding shall be initiated under this Part I until formal written charges have been filed with the secretary of the component society or the district Ethical Relations Committee, as the case may be. Thereafter, said formal written charges must be presented under oath or affirmation by the complaining party before the Ethical Relations Committee of the component society or the district Ethical Relations Committee, as the case may be.
- C. A hearing shall be held by the committee within 30 days after the formal written charges have been filed, unless continued by the chairman of the committee upon good cause shown.
- D. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold the hearing within the time period, including reasonably granted continuances, either the complaining party or the physician, against whom formal written charges have been brought, may appeal for relief and hearing to the district Ethical Relations Committee, which will determine the reasonableness of the effort.
- E. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the hearing, together with a statement of the rights of the charged individual as follows:
  1. to be represented by any member of the society as counsel and that he may have legal counsel present;
  2. to cross-examine witnesses;
  3. to offer in evidence any pertinent records or documents;
  4. to object to any testimony or exhibits offered in evidence;
  5. to address the hearing body in his own behalf;
  6. to be tried only on the specific charges filed;
  7. to have stricken from the record any improper testimony or exhibits;
  8. to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record, tape recording or its equivalent of the entire proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record, tape recording or its equivalent, of the entire proceedings shall be forwarded by certified mail to the Board of Trustees of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the charged individual not guilty.

Section 6. *Verdict.* The committee, sitting as a hearing body, shall recommend the charged individual be found either guilty or not guilty. If the verdict is guilty, the



hearing body shall recommend censure, suspension or expulsion.

The findings of the hearing body must be presented to the component county society for approval or rejection. The charged individual must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the component society are against the charged individual, the secretary of the component society shall acquaint the charged individual by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

## PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record tape recording or its equivalent, of the entire proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of the Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. *Verdict.* The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. *Notification and right of appeal.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

## CHAPTER XII. PEER REVIEW

### PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Peer Review Committee.* Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing the various specialties, including family practice, as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with the Illinois State Medical Society within 30 days after the final opinion of the county or district committee has been rendered.

## PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review, which shall review opinions of the county or district peer review committee. The council shall have the power to counsel with and obtain information from medical specialists when appropriate. The Council shall have the power to review both the procedural and substantive aspects of any appeal before it.

Section 2. The council upon receiving notice of an appeal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with in-

vestigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing back to the component society.

### CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

### CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

### CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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# 1976-1977

## Policy Manual

### of the

## Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the standard taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

## PROFESSIONAL POLICIES

### Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Performance of abortions should be carried out in accordance with current guidelines as promulgated by the House of Delegates. If not in conflict with state and federal law, an abortion so performed shall not be considered unethical. No physician shall be required to perform or participate in an abortion.

## **Acupuncture**

Acupuncture is a surgical procedure and its practice should be limited to physicians licensed to practice medicine in all of its branches and to dentists.

## **Alcoholism**

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.

Insurance companies are encouraged to include appropriate coverage for alcoholism in health insurance policies similar to coverage for any other illness and general hospitals, both public and private, are encouraged to accept alcoholic patients (both in-patient and out-patient) for detoxification and rehabilitation.

## **Alcoholism Education**

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that mental health clinics should enlarge their services to include treatment and counseling of alcoholics and their families and, where appropriate, collaborate with Alcoholics Anonymous as well as half-way houses; that education programs aimed at alcohol abusers who are drivers should be encouraged and legal restrictions established to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects should be encouraged.

## **Ambulance Services**

All ambulance services should meet minimum standards as developed from time to time by the Illinois State Medical Society and the State of Illinois.

## **Athletic Programs**

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

## **Audits & Surveys (Hospital, nursing homes, etc.)**

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

## **Birth Control**

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

## **Blood Procurement**

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

## **Communicable Diseases**

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

## **Community Health Week**

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities during the winter or spring of the year.

## **Comprehensive Health Planning**

Upgrading of local health facilities should be implemented through Comprehensive Health Planning on a home rule basis rather than through metropolitan oriented advisory services. Where a county medical society is unable to enter into meaningful participation in areawide health services planning, this function may be assumed by an appropriate ISMS District Committee or, where the appropriate District Committee is unable to act, by the Illinois State Medical Society.

## **Confidentiality**

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles of Medical Ethics states that "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society will take an active role in uncovering any violation of the doctor-patient confidential relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

ISMS is in total opposition to the use of the Social Security number as a universal number identifier.

## **Conflict of Interest**

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.



## Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

In the certification of educational quality of continuing medical education programs, the Illinois State Medical Society should have a primary role. Physicians should be encouraged to participate in self-assessment test programs prior to registering for such hospital courses and other learning activities.

## Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

## Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

## Discrimination—(see "Freedom of Choice")

## Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct supervision by such physicians.

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.

## Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.

## Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

## Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

## Experimental Medical Procedures

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied in connection with the use of experimental drugs or procedures:

1. The voluntary consent of the person on whom the experiment is to be performed should be obtained.
2. The danger of each experiment must be previously investigated by animal experimentation.
3. The experiment must be performed under proper medical protection and management.

## Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS will vigorously oppose any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.

## Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees. Fees should be commensurate with services rendered.

## Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

## Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost. Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

## Governmental Health Insurance Programs

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.

## **Health Care—Ancillary Services**

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, problems of migrant workers, etc., and any other area which involves the health of the people of this state.)

## **Health Care Costs**

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

## **Health Careers**

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

## **Health Screening by Paramedical Personnel**

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.

## **Hospitals**

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

The Illinois State Medical Society encourages the development of local peer review plans for appropriate review of utilization of hospital emergency rooms.

## **Hospital-Medical Staff-Management Relationship**

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and

assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on a medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of a hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

## **Hospital Records and Their Availability**

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when needed, to insurance companies, governmental agencies, consulting physicians, etc.

## **Hospital Staff Assessments**

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

## **Immunization Program**

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

County medical societies should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate for coordination of the immunization program).

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.

## **Impartial Medical Testimony**

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

## **Indigent, The Care of the**

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care



for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

### **Insurance Plans for Patients**

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

### **Laboratories**

All laboratories providing medical data should be under the direct supervision of a physician.

### **Legal Definition of Death**

ISMS will not support any legislative proposal which seeks to define death unless it provides that, based upon usual and reasonable standards of medical practice, death has occurred when it is determined by a doctor of medicine that a person has experienced the permanent and irreversible cessation of the integrated functioning of the respiratory, circulatory and nervous system, according to the following standards:

- (a) the irreversible cessation of spontaneous respiratory and circulatory functions; or
- (b) if artificial means of support preclude reliance on item (a), the irreversible cessation of spontaneous brain function, which may be confirmed by a flat (isoelectric) electroencephalographic tracing in the absence of hypothermia and of barbiturate and other nervous system depressants.

### **Marijuana**

ISMS continues to discourage the use of marijuana. While ISMS supports decriminalization of possession of reasonably small amounts of it for personal use, thus removing criminal penalties while assessing civil penalties, it does not endorse the possession or use of marijuana.

Since medical and psychiatric knowledge concerning the short-term and long-term effect of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.

### **Medical Care, Provision of**

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

### **Medical Diagnosis and Treatment**

Third parties, including government personnel, insurance carriers, review organizations and hospital personnel should be informed and educated that the Illinois State Medical Society endorses the concept that prognosis and

length of treatment must always be individualized to the patient, rather than to the diagnosis.

### **Medical Education**

The Illinois State Medical Society supports development of innovative curricular and co-curricular programs in medical education maintaining a firm foundation in the basic sciences.

### **Medical Examiners**

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

### **Medical Psychotherapy**

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches, who has had training in psychiatric medicine.

### **Mental Health**

The Illinois State Medical Society strongly opposes the double standard of care in state hospitals and favors elimination of permit physicians (unlicensed physicians practicing in state institutions). Every effort should be made to extend educational opportunities to these permit physicians to enable them to achieve full licensure.

Each constituent county society should cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, i.e., crisis intervention, to be available statewide.

All physician or other health service provided to the Department of Mental Health, other than that by full-time employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

### **Minors, Medical Treatment of**

Where parental consent is not legally required for medical treatment of minors, the physician's judgment shall prevail as to whether or not the parents should be notified of such treatment.

### **Multiphasic Screening**

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic

health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

### **Nurses—Shortage**

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

### **Nursing Homes**

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.

### **Nutrition**

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the Nutrition Committee and the Council on Environmental and Community Health in 1971.

### **Occupational Health**

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of industrial physicians.

### **Osteopaths, Association with**

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

### **Physician-Patient Relationship**

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

### **Prepayment Plans and Organizations**

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Such plans should recognize that free standing medical and surgical facilities are acceptable methods of delivering high quality health care. Reimbursement for expenses incurred as an outpatient in such facilities should be included in the benefits of these plans.

### **Prolonging Human Life**

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.

### **Psychosurgery**

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.

### **Public Aid**

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and co-operating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

### **Public Health Departments**

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

Local public health service jurisdictions should be consolidated into sufficiently large geographic and population districts to achieve program efficiency.

### **Public Safety**

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

### **Rehabilitation**

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.



Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

### **Relative Value**

The Relative Value Study is not a fee schedule and is to be used for information only. All fee payments should be based on the usual, customary and reasonable concept.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon recommendation of the Relative Value Committee with approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

### **Smoking**

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

### **Specialty Society Representation on ISMS Councils**

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

### **Veterans Administration**

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

## **ADMINISTRATIVE POLICIES**

### **AMA-ERF**

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

### **Assessments**

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

### **Autonomy of County Medical Societies**

In all areas, the county medical society shall be autonomous, except that no ruling by any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association or with the Constitution and Bylaws of the Illinois State Medical Society.

### **Birth Certificates**

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

### **Budgets—(see "Financial Policies")**

### **Committee Appointments**

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

### **Constitution and Bylaws**

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

### **Co-operation with the American Medical Association**

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

### **Dues, Recommendation of the Board to the House**

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration by the Board of Trustees in time for the Board to present its recommendations to the House of Delegates each year.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

### **Education, Primary and Secondary**

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

## Election of AMA Delegates

Delegates to the American Medical Association should almost without exception be elected from those having served first as alternate delegates.

## Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

## Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

## Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

(7) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

## House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

## ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils and committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee.

## Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

## Journal Publications

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

## Lay Employees' Functions

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

change existing policy

establish new policy

request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

## Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

## Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.



## Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.

## Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

## Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Unless physicians appointed to the boards and committees of other organizations, such as local Comprehensive Health Planning "b" agencies, are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

## Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

## Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

## Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

## Policy Statements

Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society af-

fairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

## Polls, Opinion

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion has been expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

The Board of Trustees should utilize various innovative methods in order to ascertain the most effective means of obtaining the opinions of the membership and ISMS should conduct periodic membership opinion polls on critical basic issues facing the society.

## Press

All county medical societies should be encouraged to cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

## Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians including the right of individual physicians to appear before appropriate peer review committees responsible for his liability insurance coverage.

The Illinois State Medical Society should protect the interests of its members by encouraging the provision of a guarantee of due process in the bylaws of the Illinois State Medical Inter-Insurance Exchange.

## Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal*, or any other media, extreme care should be exercised. The welfare and privacy of the patient, and the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

## Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

## **Rebates**

In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical. This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

## **Reference Committee Appointments**

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

## **Reference Service**

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

## **Stationery, Use of Official**

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical

Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

## **Surveys**

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

## **Uniform Health Insurance Claim Form**

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.

## **ISMS Auxiliary**

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

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# **Policy Manual**

## **APPENDIX**

### **Multiphasic Health Testing Council on Environmental and Community Health Statement**

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomatic control patients have been tested. Testings

have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.



Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up on commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination of medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic

health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

## AMA Guidelines for Establishing and Operating Multiphasic Health Testing Programs

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians must be involved in the planning and development of testing programs.
4. The operation of all MHT programs must be supervised by qualified physicians at the testing center, particularly in regard to any abnormal findings, and these physicians must see that the patient is instructed to obtain medical advice for significant abnormal findings.
5. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
6. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform,

and that have acceptable sensitivity, specificity, high predictive value, and patient acceptance.

7. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
8. The program should provide for confidentiality of patient data.
9. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
10. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
11. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
12. The program should maintain freedom of choice for both the physician and the patient.

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Newton DuPuy .....1968  
Harlan English .....1964  
Edwin S. Hamilton .....1962  
H. Close Hesseltine .....1961  
J. M. Ingalls .....1976  
Charles J. Jannings, III .....1972  
Frank J. Jirka, Jr. ....1973  
Fredric D. Lake .....1975  
Willis I. Lewis .....1954  
Burtis E. Montgomery .....1966  
Edward A. Piszczek .....1965  
Caesar Portes .....1967  
Willard C. Scrivner .....1974  
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Andrew J. Brislen .....1974-1975  
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Maurice M. Hoeltgen, Chicago .....1967-1970  
Paul W. Sunderland, Gibson City .....1970-1973



# ISMS DELEGATION TO THE AMA

## Delegates

*To Serve from Jan. 1, 1975 to Dec. 31, 1976*  
(Elected April 6, 1974)

Carl E. Clark  
225 Edward St., Sycamore 60178  
Alfred J. Faber  
2110 Swainwood Dr., Glenview 60025  
H. Close Hesseltine  
5807 S. Dorchester Ave., Chicago 60637  
Maurice M. Hoeltgen  
4700 W. 95th St., Oak Lawn 60453  
William M. Lees  
6518 N. Nokomis Ave., Lincolnwood 60646  
John J. Ring  
511 E. Hawley St., Mundelein 60060  
Charles K. Wells  
117 N. 10th St., Mt. Vernon 62864

*To Serve from Jan 1, 1976 to Dec. 31, 1977*  
(Elected April 5, 1975)

Herschel Browns1  
4600 N. Ravenswood, Chicago 60640  
Howard C. Burkhead  
130 Dempster St., Evanston 60202  
Jack Gibbs  
175 S. Main St., Canton 61520  
Theodore Grevas  
2701-17th St., Rock Island 61201  
Morgan M. Meyer  
815 S. Main St., Lombard 60148  
Edward A. Piszczek  
6410 N. Leona Ave., Chicago 60646

*Delegation Chairman: Edward A Piszczek; Secretary: Jack Gibbs*

Fred A. Tworoger  
4753 N. Broadway, Chicago 60640

*To Serve from Jan. 1, 1977 to Dec. 31, 1978*  
(Elected April 28, 1976)

Allison L. Burdick, Jr.  
1637 N. Mobile Ave., Chicago 60639  
Alfred J. Faber  
2110 Swainwood, Glenview 60025  
David S. Fox  
826 E. 61st St., Chicago 60637  
Lawrence L. Hirsch  
2434 Grace, Chicago 60618  
Joseph R. O'Donnell  
444 Park Blvd., Glen Ellyn 60137  
John J. Ring  
511 E. Hawley St., Mundelein 60060  
Charles K. Wells  
117 N. 10th St., Mt. Vernon

## Honorary Delegates

Walter C. Bornemeier  
19273 Harleigh Dr., Saratoga, Cal. 95070  
Edwin S. Hamilton  
985 Cobb St., Kankakee 60901  
Frank J. Jirka, Jr.  
1507 Keystone Ave., River Forest 60305  
Burtis E. Montgomery  
37 S. Main St., Harrisburg 62946

## Alternate Delegates

*To Serve from Jan. 1, 1975 to Dec. 31, 1976*  
(Elected April 6, 1974)

David S. Fox  
826 E. 61st St., Chicago 60637  
Lawrence L. Hirsch  
2434 Grace, Chicago 60618  
Robert P. Johnson  
108 Maple Grove, Springfield 62707  
Fredric D. Lake  
999 Michigan Ave., Evanston 60202  
Eugene T. Leonard  
3 Crestwood Lane, Rockford 61107  
Theodore R. Van Dellen  
200 E. Chestnut St., Chicago 60611

*To Serve from Jan. 1, 1976 to Dec. 31, 1977*  
(Elected April 5, 1975)

Robert R. Hartman2  
1515A Walnut St., Jacksonville 62650  
J. M. Ingalls  
502 Shaw Ave., Paris 61944  
Eugene P. Johnson3  
P.O. Box 68, Casey 62420  
Joseph B. Moles4  
715 Lake St., Oak Park 60301  
George Shropshear5  
1525 E. 53rd St., Chicago 60615

Glen Tomlinson  
4 Professional Park, Lincoln 62656  
George T. Wilkins  
3165 Myrtle Ave., Granite City 62040

*To Service from Jan. 1, 1977 to Dec. 31, 1978*  
(Elected April 28, 1976)

Henrietta Herbsolsheimer  
5528 S. Hyde Park Blvd., Chicago 60637  
Joseph H. Skom  
707 Fairbanks Ct., Chicago 60611  
Robert P. Johnson  
108 Maple Grove, Springfield 62707  
Andrew Thomson, Jr.  
3040 Grant, Evanston 60201  
Fredric D. Lake  
999 Michigan Ave., Evanston 60202  
Eugene T. Leonard  
3 Crestwood Lane, Rockford 61107  
Charles Schlageter  
707 N. Fairbanks Ct., Chicago 60611

1Elected to 14th delegate position  
2Elected to fill unexpired term of Joseph R. O'Donnell  
3Elected to fill 14th alternate delegate position  
4Elected to fill unexpired term of Herschel Browns  
5Resigned April 28, 1976

# Officers of County Medical Societies

## 1976

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WABASH Members: 7-Dist. 9	T. R. Young 512 Market St., Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863

COUNTY	PRESIDENT	SECRETARY
WARREN Members: 11-Dist. 4	W. Roller 309 S. Main, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
WASHINGTON Members: 4-Dist. 10	Charles Longwell 111 S. Washington, Nashville 62263	Jerry L. Beguelin Box 197, Irvington 62848
WAYNE Members: 9-Dist. 9	Arthur R. Marks 101 E. Center, Fairfield 62837	D. A. Gershenson 308 E. Main, Fairfield 62837
WHITE Members: 8-Dist. 9	Morris McCall 12 College Ave., Carmi 62821	J. A. Stricklin Carmi 62821
WHITESIDE Members: 44-Dist. 1A	J. P. McGee 1716 Locust, Sterling 61081	Jose Pino 1913 Avenue F, Sterling 61081
WILL-GRUNDY Members: 202-Dist. 11 Ron Bryant, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Guy A. Pandola 333 N. Madison, Joliet 60435	Robert J. Kramer 3077 W. Jefferson, Joliet 60435
WILLIAMSON Members: 37-Dist. 9	Vinai Sawetawan 121 N. 13th St., Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918
WINNEBAGO Members: 330-Dist. 1A Mrs. Johanna Lund Exec. Adm. 310 N. Wyman St. Rockford 61101	Keith L. Wrage 2500 N. Rockton, Rockford 61103	John English 1316 Charles, Rockford 61101
WOODFORD Members: 6-Dist. 2	Victor Jay 601 N. Jefferson, Washburn 61570	James W. Riley 109 S. Major, Eureka 61530

#### No Organized County Society

Johnson  
Marshall  
Putnam

#### Joint County Societies

Cass-Brown  
Coles-Cumberland  
Henry-Stark  
Jefferson-Hamilton  
Jersey-Calhoun  
Morgan-Scott  
Saline-Pope-Hardin  
Will-Grundy

*A major portion of this listing may become obsolete as of January, 1977. An up-to-date listing will be published in the delegates hand-book section of the March issue of the Illinois Medical Journal.*

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in this Reference Issue. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: (     ) \_\_\_\_\_

COUNTY MEDICAL SOCIETY: \_\_\_\_\_

MEDICAL SPECIALTY AND TYPE OF PRACTICE \_\_\_\_\_

COMMITTEE IN WHICH INTERESTED: \_\_\_\_\_

EXPERTISE FOR THIS COMMITTEE: \_\_\_\_\_

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society  
55 E. Monroe, Suite 3510, Chicago, IL 60603





## TRUSTEE DISTRICT COMMITTEES

### First District

Joseph L. Bordenave, Geneva, *Trustee*  
Counties of Kane, Lake, McHenry

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
David Clark, Aurora .....	1978
Emanuel Herzon, Elgin .....	1978
Gerald Liesen, St. Charles .....	1979
A. M. Rosetti, McHenry .....	1977
David Helberg, Waukegan .....	1978
Eugene Pitts, Waukegan .....	1978
James Pritchard, Geneva .....	1978
Peter Vinceguerra, Libertyville .....	1978

### I-A District

P. John Seward, Rockford, *Trustee*  
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle,  
Stephenson, Whiteside, Winnebago

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
John H. Steinkamp, Belvidere, <i>Chairman</i> .....	1978

#### PEER REVIEW COMMITTEE

Robert Behmer, Rockford, <i>Chairman</i> .....	1977
Frank Luedke, DeKalb .....	1978
John L. Clark, Freeport .....	1979

### Second District

Allan L. Goslin, Streator, *Trustee*  
Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
K. Dexter Nelson, Princeton, <i>Chairman</i> .....	1977
William Erkonen, Streator .....	1978
Tim Sullivan, Sterling .....	1979

#### PEER REVIEW COMMITTEE

Louis Tarsinos, Princeton, <i>Chairman</i> .....	1979
James B. Aplington, LaSalle .....	1979
Francis J. Brennan, Utica .....	1979
Silvio Davito, Spring Valley .....	1979
Bernard J. Doyle, LaSalle .....	1979
William Ehling, Streator .....	1977
P. Lymberopoulos, Princeton .....	1979
Rowland Musick, Mendota .....	1979
Theodore Mauger, Chatsworth .....	1978
Theodore W. Wagenknecht, Streator .....	1979

### Third District

Alfred Clementi, Arlington Heights, *Trustee*  
Alfred J. Faber, Glenview, *Trustee*  
Robert T. Fox, Glenview, *Trustee*  
Henrietta Herbolsheimer, Chicago, *Trustee*  
Lawrence L. Hirsch, Chicago, *Trustee*  
Eugene T. Hoban, Oak Park, *Trustee*  
William M. Lees, Lincolnwood, *Trustee*  
Joseph C. Sherrick, Chicago, *Trustee*  
Philip G. Thomsen, Dolton, *Trustee*  
Herman Wing, Chicago, *Trustee*

### Fourth District

Fred Z. White, Chillicothe, *Trustee*  
Counties of Fulton, Hancock, Henderson, Henry, Knox,  
McDonough, Mercer, Peoria, Rock Island, Schuyler,  
Stark, Warren

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Richard Icenogle, Roseville, <i>Chairman</i> .....	1977
John Bowman, Aringdon .....	1979
George Burke, Rock Island .....	1978

#### PEER REVIEW COMMITTEE

Russell Jensen, Monmouth, <i>Chairman</i> .....	1979
William Daugherty, Moline .....	1978
Donald Dexter, Macomb .....	1977
G. W. Geibelhausen, Peoria .....	1978
James C. Parsons, Geneseo .....	1979
Clarence Ward, Peoria .....	1978

### Fifth District

Paul F. Mahon, Springfield, *Trustee*  
Counties of DeWitt, Logan, McLean, Mason, Menard,  
Montgomery, Sangamon, Tazewell

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
William W. Curtis, Springfield, <i>Chairman</i> .....	1977
Jack Means, Mason City .....	1978
A. L. Van Ness, Bloomington .....	1979

#### PEER REVIEW COMMITTEE

James Borgerson, Mt. Pulaski, <i>Chairman</i> .....	1977
Robert Price, Bloomington, <i>Co-Chairman</i> .....	1977
George Irwin, Bloomington .....	1979
Paul Lafata, Springfield .....	1977
John G. Meyer, Springfield .....	1978
Alton J. Morris, Springfield .....	1979
Robert B. Perry, Lincoln .....	1979
Robert Schaefer, Petersburg .....	1978
James Weimer, Pekin .....	1979



## Sixth District

Robert R. Hartman, Jacksonville, *Trustee*  
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey,  
Macoupin Madison, Morgan, Pike, Scott

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Newton DuPuy, Quincy, <i>Chairman</i> .....	1977
Bernard Baalman, Hardin .....	1978
Edward K. DuVivier, Alton .....	1977
Joseph J. Grandone, Gillespie .....	1977

### PEER REVIEW COMMITTEE

James Reid, Greenfield, <i>Chairman</i> .....	1977
Meyer Shulman, Pittsfield, <i>Co-Chairman</i> .....	1977
E. C. Bone, Jacksonville .....	1979
Robert England, Carlinville .....	1978
Robert C. Murphy, Quincy .....	1979
B. Frank Norbury, Jacksonville .....	1978
Edward Ragsdale, Alton .....	1977
James Sutherland, Quincy .....	1977

## Seventh District

Alfred J. Kiessel, Decatur, *Trustee*  
Counties of Bond, Christian, Clay, Clinton, Effingham,  
Fayette, Macon, Marion, Moultrie, Piatt, Shelby

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
C. R. Daisy, Greenville, <i>Chairman</i> .....	1978
D. M. Rames, Vandalia .....	1979
Charles Stanley, Decatur .....	1979

### PEER REVIEW COMMITTEE

Stanley Moore, Vandalia, <i>Chairman</i> .....	1979
M. K. Kaufman, Greenville .....	1977
H. Gale Zacheis, Decatur .....	1977
Walter P. Plassinan, Centralia .....	1979

## Eighth District

James Laidlaw, Champaign, *Trustee*  
Counties of Champaign, Clark, Coles, Crawford, Cumber-  
land, Douglas, Edgar, Jasper, Lawrence, Richland, Ver-  
million

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Mack W. Hollowell, Charleston, <i>Chairman</i> .....	1977
James H. Pass, Olney .....	1978
Alan M. Taylor, Danville .....	1979

### PEER REVIEW COMMITTEE

E. T. Baumgart, Danville, <i>Chairman</i> .....	1977
George T. Michell, Marshall .....	1978
Michael Murray, Olney .....	1979
George Perlstein, Champaign .....	1979
C. E. Ramsey, Charleston .....	1979
Gordon Sprague, Paris .....	1979

## Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*  
Counties of Alexander, Edwards, Franklin, Gallatin, Ham-  
ilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope,  
Pulaski, Saline, Union, Wabash, Wayne, White, William-  
son

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Alex Goldstein, Harrisburg, <i>Chairman</i> .....	1979
Antonio Boba, Mt. Vernon .....	1977
Elliott Partridge, Eldorado .....	1977

### PEER REVIEW COMMITTEE

C. J. Jannings, III, Fairfield, <i>Chairman</i> .....	1979
Philip D. Boren, Carmi .....	1977
Herbert V. Fine, Cartersville .....	1978
James Heersma, Mt. Vernon .....	1979
Harry L. Lewis, Benton .....	1978
Charles K. Wells, Mt. Vernon .....	1979

## Tenth District

Julian W. Buser, Belleville, *Trustee*  
Counties of Monroe, Perry, Randolph, St. Clair, Washing-  
ton

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
H. P. Dexheimer, Belleville, <i>Chairman</i> .....	1979
Roy Kenney, E. St. Louis .....	1979
Edilberto Maglasang, Columbia .....	1979
Wm. A. Simmons, Belleville .....	1979

### PEER REVIEW COMMITTEE

William H. Walton, Belleville, <i>Chairman</i> .....	1978
Benjamin Arenas, Belleville .....	1979
Ted Bryan, Belleville .....	1979
R. W. Jost, Waterloo .....	1978
R. E. Schettler, Red Bud .....	1977

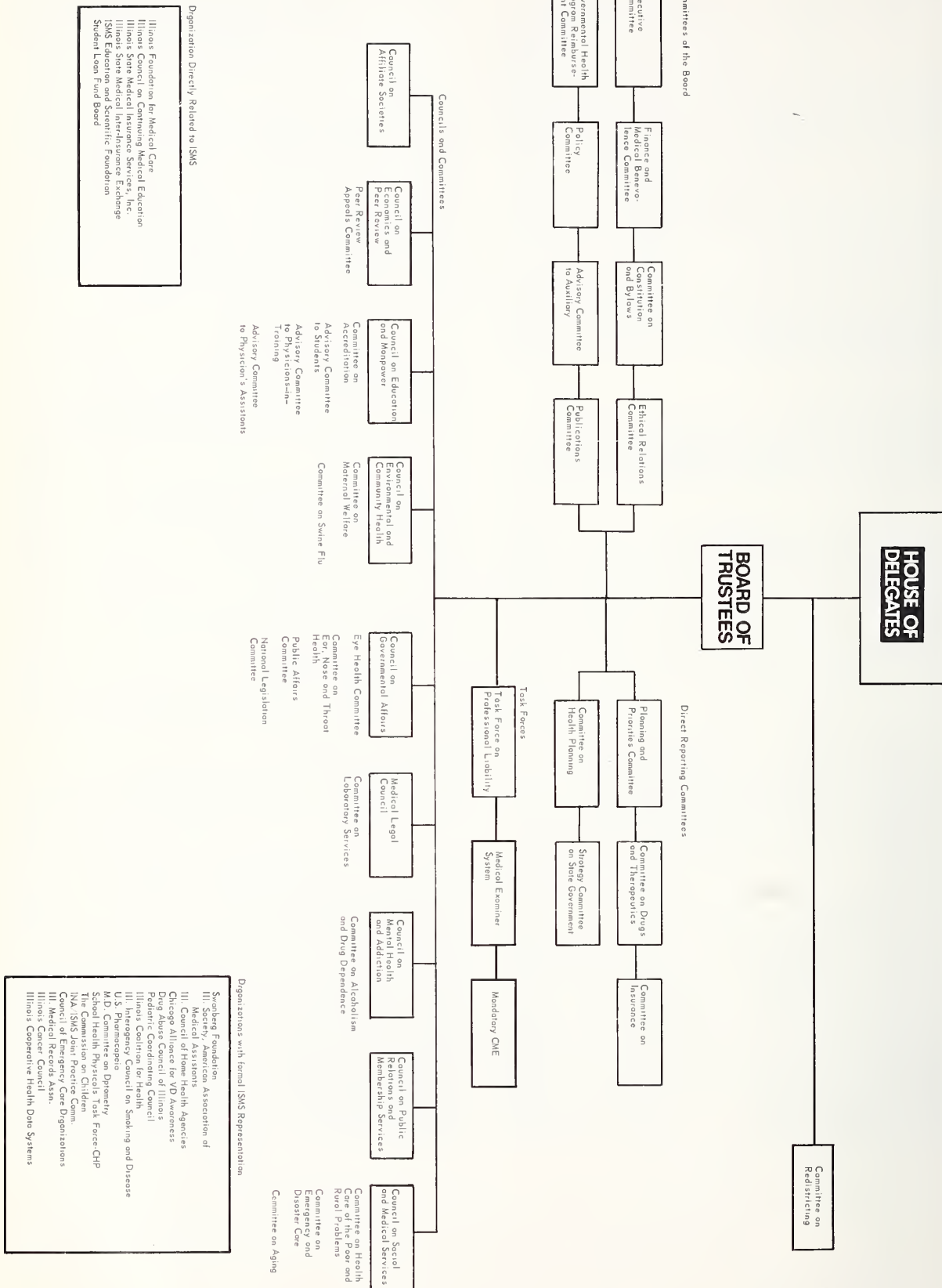
## Eleventh District

Ross N. Hutchison, Gibson City, *Trustee*  
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee,  
Kendall, Will

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
James Ryan, Kankakee, <i>Chairman</i> .....	1978
Lawrence D. Lee, Manhattan .....	1979
Merle Otto, Frankfurt .....	1979
William C. Perkins, West Chicago .....	1979

### PEER REVIEW COMMITTEE

James Campbell, Wheaton, <i>Chairman</i> .....	1978
James E. Dailey, Watseka .....	1978
James Lambert, Joliet .....	1979
Guy Pandola, Joliet .....	1978
A. G. Parkhurst, Kankakee .....	1977
W. H. Brill, Oswego .....	1977
Charles G. White .....	1979





# Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, ex-officio members of all groups.

## COUNCIL ON AFFILIATE SOCIETIES

Norman M. Frank, *Chairman*  
Ill. Chap., Amer. Academy of Family Phy.  
421 Park Ave., Clarendon Hills 60514

Robert Bettasso  
Ill. Chap., Amer. Coll. of Surgeons  
1703 Polaris Circle, Ottawa 61350

Edward Brunner  
Ill. Soc. of Anesthesiologists  
303 E. Chicago Ave., Chicago 60611

Ivan Ciric  
Ill. Neurosurgical Society  
2500 Ridge Ave., Evanston 60201

John Coleman  
Ill. Society of Internal Medicine  
7939 S. Western, Chicago 60620

Jack L. Gibbs  
Ill. Surgical Society  
175 Main St., Canton 61520

B. Jay Hill  
Ill. Radiological Society  
Mercy Hospital, King Dr. and Stevenson Exp.,  
Chicago 60616

M. Barry Kirschenbaum  
Ill. Dermatological Society  
6450 North California, Chicago 60645

Edward Lyon  
Chicago Urological Society  
950 E. 59th St., Hospital Box 403, Chicago 60637

John J. McLaughlin  
Ill. OB-GYN Society  
2100 Glenwood, Joliet 60435

Robert C. Muehrcke  
Ill. Chap., Amer. College of Physicians  
12 Croydon Lane, Oak Brook 60521

Richard Novak  
Illinois Society of Pathology  
Rockford Memorial Hospital, 2400 North Rockton,  
Rockford 61103

Joseph Paxhia  
Illinois Association of Ophthalmology  
940 Lee Street, Des Plaines 60016

Albert L. Pisani  
Ill. Chap., American Academy of Pediatrics  
40 South Clay Street, Hinsdale 60521  
(Lawrence Breslow, Alternate, 1500 Shermer Rd.,  
Northbrook 60062)

Robert W. Ridley  
Illinois Society of Ophthalmology & Otolaryngology  
Coleman Clinic, 175 South Main Street, Canton 61520

David L. Rosenberg  
Ill. Psychiatric Society  
1893 Sheridan Rd., Highland Park 60035

William H. Schwengel  
Ill. Orthopedic Society  
1240 N. Highland, Aurora 60506

Bill B. Smiley  
Ill. Chap., Amer. Coll. of Emer. Phy.  
2155 Hoyt Ct., Decatur 62526

E. B. Sylvester  
Ill. Section, Amer. Coll. of OB-GYN  
57 N. Ottawa, Joliet 60431

STAFF: Larry S. Boress

### Responsibilities and Purposes:

To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

## COUNCIL ON ECONOMICS AND PEER REVIEW

Joseph R. O'Donnell, *Chairman*  
444 Park, Glen Ellyn 60137

Carroll Boyles  
1606 Margaret Lane, DeKalb 60115

Howard C. Fishman  
Hines V.A. Hospital, Hines 60141

William A. Hutchison  
2238 N. Lincoln Park W., Chicago 60614

A. Beaumont Johnson  
860 Summit, Elgin 60120

Martin P. Meisenheimer  
605 W. Central Rd., Arlington Heights 60005

Michael E. Murray  
610 S. Elliott, Olney 62450

Herbert Natof  
1710 Cloverdale, Highland Park 60035

Roger N. Pesch  
26 W 171 Roosevelt Rd., Wheaton 60187

Joseph Silverstein  
1616 Sheridan Rd., Wilmette 60091

Alex Spadoni  
2301 Glenwood Ave., Joliet 60435

Fred A. Tworoger  
4753 Broadway, Chicago 60640

Ben Williams  
1400 W. Park Ave., Urbana 61801

CONSULTANT:  
Cyril C. Wiggishoff  
25 East Washington Street, Chicago 60602

INTERN/RESIDENT  
Bryan Schnltz  
600 North McClurg Court, #3504, Chicago 60611

STUDENT  
Bernard Sakowicz  
1229 Isabella, Evanston 60201

STAFF: Alexander R. Lerner

**Committee:**

Peer Review Appeals

**Responsibilities and Purposes:**

The Council on Economics & Peer Review shall concern itself with: 1) relations with the health insurance

industry and prepayment plans; 2) fees and fee adjudication as promulgated by the ISMS; 3) health care cost and utilization; 4) new modes of health care delivery (prepaid programs, surgicenters, etc.).

**PEER REVIEW APPEALS COMMITTEE**

Michael E. Murray, *Chairman*

Howard C. Fishman

A. Beaumont Johnson

Martin P. Meisenheimer

Herbert Natof

Ben Williams

STAFF: Larry S. Boress

**Responsibilities and Purposes:**

The Peer Review Appeals Committee serves as the appellate body for peer review in the state. It considers cases being appealed from local or district Peer Review committees involving quality and cost of medical care. The committee also serves as liaison to local peer review committees and offers its assistance whenever requested.

**COUNCIL ON EDUCATION AND MANPOWER**

Allison L. Burdick, Jr., *Chairman*

1637 North Mobile, Chicago 60639

Milda Budrys

990 Lake Shore Dr., Apt. 10B, Chicago 60611

Dean Bordeaux

221 N.E. Glen Oak Ave., Peoria 61636

William Jackson

602 W. University Ave., Urbana 61801

Eugene T. Leonard

5670 E. State St., Doctors Park, Rockford 61108

Joseph P. McKay

533 W. North Ave., Elmhurst 60126

Charles T. McHugh

2520 N. Lakeview, Chicago 60614

David Roxe

250 E. Superior, Chicago 60611

Eugene J. Scherba

13826 Lincoln, Dolton 60419

Vernon L. Zech

2615 W. Washington St., Waukegan 60085

**RESIDENT**

Michael Hughey

711 Laurel Ave., Wilmette 60091

**STUDENT**

Ira Felman

5744 S. Drexel, Apt. 3B, Chicago 60637

**CONSULTANTS**

Lawrence Hirsch

2434 W. Grace St., Chicago 60618

Ross Hutchison

126 E. Ninth, Gibson City 60936

William M. Lees

6518 N. Nokomis, Lincolnwood 60646

STAFF: Perry L. Smithers

**Responsibilities and Purposes:**

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for paramedical personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with the advisory committee to students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

**Committees:**

Accreditation

Advisory Committee to Medical Students

Advisory Committee to Physician's Assistants

Advisory Committee to Physicians-in-Training

**COMMITTEE ON ACCREDITATION**

Dean R. Bordeaux, *Chairman*

221 N.E. Glen Oak Ave., Peoria 61636

Philip D. Anderson

Swedish Covenant Hospital

5415 N. California, Chicago 60625

H. Close Hesseltine

5807 S. Dorchester, Chicago 60637

Rex O. McMorris

619 N.E. Glen Oak Ave., Peoria 61603

Julius S. Newman

157 S. Lincoln Ave., Aurora 60505

**CONSULTANT:**

William M. Lees

6518 N. Nokomis, Lincolnwood 60646

STAFF: Perry L. Smithers

**Responsibilities and Purposes:**

To review survey reports of institutions which have applied for accredited status and grant accreditation to promote Continuing Medical Education activities; to provide liaison with the Illinois Council on Continuing Medical Education.



## ADVISORY COMMITTEE TO MEDICAL STUDENTS

Charles F. Eddingfield  
Memorial Hospital, Carthage 62321  
Richard J. Jones  
4920 S. Kenwood, Chicago 60615  
John M. Moran  
150 Nuttall Rd., Riverside 60546  
David Roxe  
250 E. Superior, Chicago 60611

STUDENTS  
Ira E. Felman (U of Chicago)  
5744 S. Drexel, Apt. 3B, Chicago 60637  
Linda Wagner (MECO)  
5936 N. Christiana, Chicago 60659  
William L. Dunn (Chicago Medical School)  
7208 Harvard, Apt. 1A, Forest Park 60130  
Stuart Oserman (U. of Ill.)  
8452 Avers Ave., Skokie 60076  
Jason Chao (Northwestern)  
60 E. Chicago, Chicago 60611  
STAFF: Perry L. Smithers

## ADVISORY COMMITTEE TO PHYSICIANS-IN-TRAINING

Vernon L. Zech, *Chairman*  
St. Therese Hospital,  
2615 W. Washington St., Waukegan 60085  
George J. Gertz  
7531 Stony Island Ave., Chicago 60649  
Norma B. Goldberg  
8500 W. Carol St., Niles 60648  
Ronald T. Staubly  
901 First St., Springfield 62704  
Donald H. Wortmann  
1429 Myott Ave., Rockford 61101

RESIDENTS:  
Michael Hughey (Evanston)  
711 Laurel Ave., Wilmette 60091  
Ira Isaacson (Northwestern Memorial)  
600 N. McClurg Ct. #3509, Chicago 60611  
Michael Kaufman  
555 W. Cornelia, #2006, Chicago 60657  
K. Thomas Papreck (Springfield Memorial)  
2205 Lynnhaven, Springfield 62704  
Paul M. Stromborg (Hines)  
1741 N. Neva, Chicago 60635  
Gregory Teas (Loyola)  
3437 W. Adams St., Chicago 60624  
STAFF: Perry L. Smithers

## ADVISORY COMMITTEE TO PHYSICIAN'S ASSISTANTS

Charles T. McHugh, *Chairman*  
2520 N. Lakeview, Chicago 60614  
Charles J. Jannings, III  
101 E. Center Street, Fairfield 62837  
Conrad Tasche  
2026 B North Cleveland, Chicago 60614

CONSULTANTS:  
Joseph L. Bordenave  
415 S. 2nd Street, Geneva 60134  
J. M. Ingalls  
502 Shaw Ave., Paris 61944  
STAFF: Perry L. Smithers

## COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

Julius M. Kowalski, *Chairman*  
436 Park Ave., E., Princeton 61356  
William W. Curtis  
100 W. Miller, Springfield 62702  
Thomas H. Davison  
17 N. Clinton St., Chicago 60606  
Edward A. Galapeaux  
4340 W. 95th St., Oak Lawn 60453  
David Littman  
1034 Old Elm Road, Highland Park 60035  
Daniel J. Pachman  
2315 E. 93rd St., Chicago 60617  
Irwin A. Smith  
1141 Church St., Northbrook 60062  
Gerald Staub  
2400 N. Rockton, Rockford 61101  
Charles L. Swarts  
715 South Blvd., Oak Park 60302  
Charles H. Westfall  
341 Prospect Ave., Elmhurst 60126

### CONSULTANTS:

Byron Francis, IDPH  
535 W. Jefferson St., Springfield 62761  
Robert R. Hartman  
1515A Walnut, Jacksonville 62650  
Henrietta Herbolzheimer  
5528 Hyde Park Blvd., Chicago 60637

### AUXILIARY:

Mrs. Joseph O'Donnell  
1109 E. Willow, Wheaton 60187

STAFF: Larry S. Boress

### Responsibilities and Purposes:

The Council on Environmental & Community Health shall cooperate with the Illinois Department of Public Health in the maintenance, protection and improvement of the health of the people of Illinois.

It shall serve as a source of information on chronic illness and communicable diseases and cooperate with institutions and voluntary health agencies in disseminating such information.

It is responsible for medicine's interest in the relationship of man to his surroundings, particularly air, water and soil pollution; health problems related to population growth, urbanization and technological development bearing on the ecology of man.

The Council also shall be concerned with diseases and problems associated with occupational and industrial health, cooperate with the Council on Occupational Health of AMA, Industrial Medical Association and similar state agencies and recommend to the State of Illinois Workman's Compensation Board medical procedures designed to assist the Board in the evaluation of claims.

### Committees:

Maternal Welfare  
Ad Hoe Committee on Swine Flu Immunization

## COMMITTEE ON MATERNAL WELFARE

### DISTRICTS MEMBERS AND ALTERNATES

(alternates in italics)

William W. Curtis, *Chairman*

100 W. Miller, Springfield 62702

1. Hugh C. Falls

700 Westmoreland, Lake Forest 60045

*Gan L. Tjiook*

123 South St., Geneva 60134

1A. Gerald F. Staub

2400 N. Rockton, Rockford 61103

*John F. Hubbard*

101 E. Miller Rd., Sterling 61081

2. William J. Farley

710 Peoria St., Peru 61354

*Carl P. Mattioda*

65 Sunset Drive, Streator 61364

3. Alex Kaz

15400 S. Page, Harvey 60426

*Charles F. Kramer*

12647 S. Justine St., Calumet Park 60643

4. Ralph Gibson

416 St. Mark Ct., Peoria 61603

*Raoul E. Reinertsen*

Coleman Clinic, Canton 61520

5. William W. Curtis

100 W. Miller, Springfield 62702

*Robert Maletich*

1025 S. 7th St., Springfield 62703

6. Richard D. Yoder

601 E. 3rd St., Alton 62002

*Donald E. Hardbeck*

2856 Beltline, Alton 62002

7. Paul A. Raber

149 W. King St., Decatur 62521

*Hubert Magill*

1170 E. Riverside, Decatur 62521

8. J. Rodger Powell

Carle Clinic, 602 W. University Ave., Urbana 61801

*John C. Mason, Jr.*

715 N. Logan, Danville 61832

9. William B. Skaggs

203 N. Vine, Harrisburg 62946

*Allan G. Bennett*

Box 2347, Carbondale 62901

10. Arthur A. Smith

306 E. Eighth St., O'Fallon 62269

*Ferdinand J. Mueller*

6401 W. Main St., Belleville 62223

11. John J. McLaughlin

2100 Glenwood Ave., Joliet 60435

*Charles P. Westfall*

341 Prospect Ave., Elmhurst 60126

### CONSULTANTS:

Robert R. Hartman

1515A Walnut St., Jacksonville 62650

John Louis

347 Circle Lane, Lake Forest 60005

Augusta Webster

707 N. Fairbanks Ct., Chicago 60611

STAFF: Larry S. Boress

## AD HOC COMMITTEE ON THE SWINE FLU IMMUNIZATION PROGRAM

Robert R. Hartman

1515A West Walnut, Jacksonville 62650

Henrietta Herbolzheimer

5528 Hyde Park Boulevard, Chicago 60637

John Holland

700 North 7th Street, Springfield 62702

Edward Piszczek

6410 North Leona Avenue, Chicago 60646

Irwin Smith

1141 Church Street, Northbrook 60062

STAFF: Larry S. Boress

## GOVERNMENTAL AFFAIRS COUNCIL

Elliott Partridge, *Chairman*

1201 Pine, Eldorado 62930

Donald Aaronson

3500 Lake Shore Drive, Chicago 60657

George Burke

Rock Island Franciscan Hospital,

2701 17th Street, Rock Island 61201

Howard Burkhead

130 Dempster, Evanston 60201

James Cavanaugh, Jr.

1210 Spruce Street, Winnetka 60093

David Clark

1780 W. Galena, Aurora, 60506

Edwin Falloon

9543 S. Central Park, Evergreen Park 60642

Edward G. Ference

932 S. 2nd, Springfield

Frank J. Kresca

208 W. Green, Champaign 61820

Levon Topouzian

4640 N. Marine Dr., Chicago 60610

Tassos Nassos

3744 Whirlaway Drive, Northbrook 60062

Michael Victor, D.O.

1641 Hunter Drive, Wheeling 60090

### AUXILIARY REPRESENTATIVE

Mrs. Sharon Morris

1616 Leland, Springfield

### STUDENT REPRESENTATIVE

Mark R. Steveson

516 S. Circle Street, Forest Park 60130

### PHYSICIANS-IN-TRAINING REPRESENTATIVE

James D. McCullough

39 Salem Lane, Evanston 60203

### CONSULTANTS

Alfred J. Faber

Paul Mahon

Ross Hutchison

P. John Seward

James Laidlaw

George T. Wilkins

William M. Lees

Mrs. Pam Taylor

STAFF: Don Udstuen

### Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.

2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.

3. Co-operate with the AMA in similar programs.

4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

### Committees:

Ear, Nose, and Throat

Eye Health

Public Affairs

National Legislation Committee



## PUBLIC AFFAIRS COMMITTEE

Tassos Nassos, *Chairman*  
3744 Whirlaway Dr., Northbrook 60062  
Theodore Bartlett  
7447 Pottawatomie Drive, Palos Heights 60463  
Finley W. Brown, Jr.  
3100 N. Sheridan Road, Chicago  
Louis Donanville  
501 15th Street, Moline 61265  
Don Hinderliter  
Box 48, Rochelle 61068  
Donald Holder  
5670 E. State Street, Rockford 61107  
W. F. Jacobs  
6525 North Avenue, Oak Park 60302  
Paul P. Lorenz  
3108 W. Kent Drive, Carbondale 62901  
Thomas P. Meirink  
8601 W. Main Street, Belleville 62223

George T. Mitchell  
Cork Medical Center, 410 N. 2nd, Marshall 62441  
John W. Ovitiz, Jr.  
204 W. Elm, Sycamore 60178  
Albert W. Ray, Jr.  
301 N. Reed, Joliet 60435  
Herbert Sohn  
4640 N. Marine, Chicago 60640  
A. E. Steer  
701 N. Walnut, Springfield 62702  
Ronald E. Sumner  
3000 Pines, Dunlap 61525  
Joseph Hinkamp  
429 Pine Manor Drive, Wilmette 60091  
Theodore Grevas  
2701 17th Street, Rock Island 61201  
AUXILIARY REPRESENTATIVE  
Mrs. Sharon Morris  
1616 Leland, Springfield

## NATIONAL LEGISLATION COMMITTEE

Howard Burkhead, *Chairman*  
30 Dempster, Evanston 60201  
Edwin L. Falloon  
9543 S. Central Park, Evergreen Park 60642  
Elliott Partridge  
1201 Pine, Eldorado 62930  
Harry Darland  
2500 N. Rockton, Rockford 61103  
Frank J. Jirka, Jr.  
1507 Keystone, River Forest 60305

Joseph R. O'Donnell  
444 Park Blvd., Glen Ellyn 60137

### CONSULTANTS

Alfred J. Faber  
P. John Seward  
Mrs. Pam Taylor  
Philip G. Thomsen  
Herman Wing

## AD HOC EAR, NOSE, AND THROAT COMMITTEE

Jack D. Clemis, *Chairman*  
55 E. Washington, Chicago 60602  
John Ballenger  
723 Elm St., Winnetka 60093  
Irwin Horwitz  
55 E. Washington, Chicago 60602

Feliz J. Lownik  
1110 S. Park Blvd., Freeport, 61032  
Ralph Naunton  
950 E. 59th, Box 412, Chicago 60637  
Burton Soboroff  
307 N. Michigan, Chicago 60601

## AD HOC EYE HEALTH COMMITTEE

Frank J. Kresca, *Chairman*  
208 W. Green, Champaign 61820  
Charles Mullenix  
1775 Glenview Road, Glenview 60025

Burton Russman  
30 N. Michigan, Chicago 60602  
Frank Snell  
334 W. Main, Decatur 62522  
Robert W. Webb  
69A. S. 9th, East Alton 62024

## MEDICAL LEGAL COUNCIL

Eugene Vickery, *Chairman*  
202 S. Schuyler, Lena 61048  
Constantine Veremakis  
409 E. Park Drive, Belleville 62223  
Earl Suckow  
617 Glendale, Mt. Prospect 60056  
Charles Wells  
117 N. 10th St., Mt. Vernon 62864  
William Schwingel  
1240 N. Highland, Aurora 60506  
Marshall B. Segal  
2112 N. Dayton, Chicago 60626  
Leonard Klafta  
57 West Jefferson, Joliet 60431  
Frank Stuart  
950 E. 59th St., Chicago 60637  
Joseph Moles  
715 Lake St., Oak Park 60301

David Petty  
316 N. Michigan Ave., Chicago 60601  
Walter Feldman  
628 West 14th St., Chicago Heights 60411  
CONSULTANTS  
J. E. Resich  
1129 S. 2nd St., Springfield 62704  
James Habegger  
1325 N. Highland, Aurora 60506  
Alfred Kiessel  
1 Powers Lane Pl., Decatur 62521  
William Lees  
6518 N. Nokomis, Lincolnwood 60646  
HOUSE STAFF REPRESENTATIVE  
William Yasnoff  
735 W. Buckingham Pl., Chicago 60657  
STUDENT REPRESENTATIVE  
David Hopp  
5715 S. Drexel Ave., Chicago 60637

STAFF: Richard A. Ott

### Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the

panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall study recommendations of its committees for methods of elevating and maintaining the standards of medical laboratories in Illinois. In addition, the council shall be concerned with standards of practice, licensure and quackery.

### Committees:

Impartial Medical Testimony  
Laboratory Services

## COMMITTEE ON LABORATORY SERVICES

Earl Suckow, *Chairman*

617 Glendale, Mt. Prospect 60056

Bernard Stodsky

4824 N. Karlov, Chicago 60630

Robert Carrara

1725 S. Street, Box 428, Geneva 60134

Joseph O. Dean

Proctor Hospital, Peoria 61604

Earl Caldwell

2600 S. Michigan, Chicago 60616

J. Robert Thompson

1129 N. Elmwood, Oak Park 60302

### CONSULTANT:

Alfred Kiessel

1 Powers Lane Pl., Decatur 62521

STAFF: Richard A. Ott

### Responsibilities and Purposes:

The committee shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

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## COUNCIL ON MENTAL HEALTH AND ADDICTION

Patrick Staunton, *Chairman*

540 Linden, Oak Park 60302

Ronald Shlensky

251 E. Chicago, Suite 930, Chicago 60611

Warren R. Dammers

203 N. Vine St., Harrisburg 62946

Glen Tomlinson

4 Lincoln Prof. Bldg., Lincoln 62656

Anthony Busch

4401 Bellevue Place, Belleville 62223

Marvin R. DeHaan

Box 181, Curling Rand Rd., Wayne, 60184

Thomas E. Kirts

232 S. 2nd, DeKalb 60115

Geoffrey L. Levy

1100 W. Central, Arlington Heights 60005

Kermet Mehlinger (*Alcoholism & Drug Dependence*)

4901 S. Drexel, Chicago 60615

Arthur R. Traugott

602 W. University, Urbana 61801

James West, (*Alcoholism & Drug Dependence*)

2400 W. 95th St., Evergreen Park 60642

Albert S. Norris

SIU Sch. of Med., Dept. of Psychiatry, Springfield 62706

LeRoy Levitt, *Director*

Illinois Dept. of Mental Health

160 N. LaSalle St., Chicago 60601

Philip G. Thomsen

13826 Lincoln, Dolton 60419

STUDENT REPRESENTATIVE

David Brown

921 Garfield, Oak Park 60304

STAFF: Richard A. Ott

### Committee:

Alcoholism and Drug Dependence

### Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information and recommend appropriate action. It shall also be concerned with reviewing legislation related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

## COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

James West, *Co-Chairman*

2400 W. 95th St., Evergreen Park 60642

Kermit Mehlinger, *Co-Chairman*

4901 S. Drexel, Chicago 60615

Albert W. Ray

301 N. Reed, Joliet 60435

George Stanton

55 E. Washington, Chicago 60602



R. Schuller  
Route 4, Box 241, 500 W. Court Street, Kankakee 60901

W. David Steed  
1011 Lake Street, Suite 423-4, Oak Park 60301

Wayne Spenader  
203 John Street, Sublette 61367

Robert Rivers  
1665 South Street, Geneva 60134

CONSULTANTS:

Edward Senay  
1440 S. Indiana, 3rd FL., Chicago

Paul Buchholz, DDC  
300 N. State Street, Chicago 60610

Msgr. Ignatius McDermott  
126 N. DesPlaines, Chicago 60606

Robert McMahon, DACI  
122 S. DesPlaines St., Chicago 60606

STAFF: Richard A. Ott

#### Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs. The committee's functions will include: (1) study, research and dissemination of educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products, and (4) cooperate with official and non-official agencies in all matters pertaining to this subject.

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### COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Mack W. Hollowell, *Chairman*  
35 Circle Drive, Charleston 61920

Robert Boxer  
64 Old Orchard Rd., Skokie 60076

Robert Hamilton  
25 E. Washington St., Chicago 60602

Robert E. McElroy  
135 S. Kenilworth, Elmhurst 60126

Jerry G. Seidel  
120 Main, Park Ridge 60068

Alan Taylor  
1012 W. Fairchild, Danville 61832

#### CONSULTANTS:

Theodore Grevas  
2701 17th St., Rock Island 61201

Jacob E. Reisch  
1129 S. Second St., Springfield 62704

#### RESIDENT MEMBER

Ira Isaacson  
600 N. McClurg Court,  
Apt. 3509, Chicago 60611

#### STUDENT REPRESENTATIVE

Christine Berg  
Northwestern Memorial Hospital,  
710 N. Lake Shore Drive, Chicago 60611

#### AUXILIARY REPRESENTATIVE

Mrs. Robert Webb  
213 S. Charles, Edwardsville 62025

STAFF: Ned Stuppy

#### Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

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### COUNCIL ON SOCIAL AND MEDICAL SERVICES

Robert P. Johnson, *Chairman*  
108 Maple Grove, Springfield 62707

Audley F. Connor, Jr.  
3233 South King Drive, Chicago 60616

C. Larkin Flanagan  
720 North Michigan Avenue, Chicago 60611

James L. Hall  
4933 Woodlawn Avenue, Chicago 60615

Shirley A. Roy  
5019 North Sheridan Road, Chicago 60640

Joseph D. Winterhalter  
5023 Whittier Lane, Rockford 61111

#### CONSULTANTS:

Henrietta Herbolzheimer  
5528 South Hyde Park Boulevard, Chicago 60637

Herman Wing  
155 North Harbor Drive, Chicago 60601

#### INTERN/RESIDENT:

Paul Stromborg  
1741 North Neva, Chicago 60635

STAFF: Latty S. Boress

#### Committees:

Aging  
Emergency and Disaster Care  
Health Care of the Poor and Rural Problems

#### Responsibilities and Purposes:

The Council on Social and Medical Services shall initiate and implement programs related to health education, medical facilities and, in addition, the Council shall maintain liaison with the nursing profession and other health-oriented organizations, including the Illinois Department of Vocational Rehabilitation; handle problems related to aging, rural health, health care of the poor, and emergency and disaster medical services.

### COMMITTEE ON AGING

Shirley A. Roy, *Chairman*  
5019 N. Sheridan Rd., Chicago 60640

Paul Dailey  
718 S. 7th St., Springfield 62703

Larsandrew Dolan  
6016 N. Nina Ave., Chicago 60631

C. Larkin Flanagan  
720 N. Michigan Ave., Chicago 60611

A. Everett Joslyn  
557 Keystone Ave., River Forest 60305

Stanley R. Palutis  
360 Fairbank Rd., Riverside 60546

**CONSULTANTS:**

Philip G. Thomsen  
13826 Lincoln, Dolton 60419  
Mr. Herman Gruber, AMA  
535 N. Dearborn, Chicago 60610  
STAFF: Larry S. Boress

**Responsibilities and Purposes:**

The Committee is to act as a liaison between the medical profession and the Illinois Department of Aging. It is concerned with the quality of care provided in nursing facilities, and the health concerns of the non-institutional elderly.

**COMMITTEE ON EMERGENCY AND DISASTER CARE**

Joseph D. Winterhalter, *Chairman*  
5023 Whittier Lane, Rockford 61111  
Robert F. Bettasso  
1703 Polaris Circle, Ottawa 61350  
Joan Cummings  
P.O. Box 1063, Hines 60141  
Earl W. Donelan  
2425 S. Glenwood Ave., Springfield 62704  
Lee Johnson  
P.O. Box 465, Litchfield 62056  
Max Klinghoffer  
127 E. Vallette, Elmhurst 60126

John W. Otten  
416 St. Mark Ct., Peoria 61603

**CONSULTANTS:**

Joseph L. Bordenave  
415 S. 2nd St., Geneva 60134

STAFF: Larry S. Boress

**Responsibilities and Purposes:**

This committee is concerned with improving the delivery of health care in emergency situations. The committee will monitor the effectiveness of emergency medical service programs as they exist throughout the state. It will also assist local and state agencies to evaluate new programs in emergency and disaster health care.

**COMMITTEE ON HEALTH CARE OF THE POOR AND RURAL PROBLEMS**

Audley F. Connor, Jr., *Chairman*  
3233 S. King Dr., Chicago 60616  
James S. Berry  
1036 W. Stephenson St., Freeport 61032  
Helen C. Bonbrest  
2045 W. Washington Blvd., Chicago 60612  
R. L. Fuller  
1123 Chestnut, Mt. Carmel 62863  
Roy W. Kenney, Jr.  
333 N. 9th St., Suite A, East St. Louis 62201  
Alfred D. Klinger  
1515 E. 52nd Pl., Chicago 60637

**CONSULTANTS:**

Fred Z. White  
723 N. 2nd St., Chillicothe 61523  
Mr. David Knoll, SIU  
801 N. Rutledge, P.O. Box 3926, Springfield 62708

STAFF: Larry S. Boress

**Responsibilities and Purposes:**

The committee's responsibility is to mobilize and utilize the resources of the medical profession to achieve available and acceptable health care for the poor and for those living in rural areas.

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## Committees of the Board of Trustees

**COMMITTEE ON CONSTITUTION AND BYLAWS**

Fred Z. White, *Chairman*  
723 N. 2nd St., Chillicothe 61523  
David S. Fox  
826 E. 61st St., Chicago 60637  
James Laidlaw  
104 W. Clark, Champaign 61820  
James A. McDonald  
515 Oakwood Dr., Geneva 60134  
Joseph C. Sherrick  
303 E. Superior, Chicago 60611

CONSULTANT: Legal Counsel

STAFF: Perry Smithers

**Responsibilities and Purposes:**

The Committee on Constitution & Bylaws shall:

- 1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;
- 2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and
- 3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.



## ETHICAL RELATIONS COMMITTEE

Eugene T. Hoban, *Chairman*  
6429 North Avenue, Oak Park 60302  
Alfred J. Faber  
2100 Swainwood Dr., Glenview 60025  
Henrietta Herbolzheimer  
5528 S. Hyde Park Blvd., Chicago 60637  
Ross N. Hutchison  
126 East 9th Street, Gibson City 60936  
Paul F. Mahon  
326 North 7th Street, Springfield 62702  
P. John Seward  
2400 N. Rockton, Rockford 61101  
STAFF: James Slawny

### Responsibilities and Purposes:

The responsibilities and purposes of this committee are outlined in CHAPTER XI, DISCIPLINE, Part 2 *Illinois State Medical Society Procedures*.  
Section 1. Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and By-laws of the Illinois State Medical Society or its component societies and charges of misconduct of members of the Society.  
Section 2. Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board

of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record, tape recording, or its equivalent, of the entire proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty.") The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. Verdict. The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. Notification and right of appeal. The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

## EXECUTIVE COMMITTEE

Robert T. Fox, *Chairman*  
2136 Robin Crest Lane, Glenview 60025  
Joseph L. Bordenave  
415 S. 2nd St., Geneva 60134  
David S. Fox  
826 E. 61st St., Chicago 60637  
Allan L. Goslin  
712 N. Bloomington, Streator 61364  
J. M. Ingalls  
502 Shaw Ave., Paris 61944  
William M. Lees  
6518 N. Nokomis, Lincolnwood 60646  
Edward A. Piszczek  
6410 N. Leona, Chicago 60646  
Jacob E. Reisch  
1129 S. 2nd St., Springfield 62704  
Joseph H. Skom  
707 Fairbanks Ct., Chicago 60611  
George T. Wilkins  
3165 Myrtle, Granite City 62040

### CONSULTANT:

James A. McDonald  
515 Oakwood Dr., Geneva 60134

STAFF: Roger N. White

### Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board provided he is still a Trustee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

## FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

William M. Lees, *Chairman*  
6518 N. Nokomis, Lincolnwood 60646  
Alfred Clementi  
675 W. Central Rd., Arlington Heights 60005  
Ross N. Hutchison  
126 East Ninth St., Gibson City 60936  
Jacob E. Reisch  
1129 South 2nd Street, Springfield 62704

### STAFF:

Roger N. White  
Richard D. Hengl

### Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.

2. Keep the names of the beneficiaries confidential and known only to the committee.

3. Determine the allotment for each recipient.

4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

#### COMMITTEE ON GOVERNMENTAL HEALTH PROGRAM REIMBURSEMENT

Robert R. Hartman, *Chairman*  
1515A W. Walnut, Jacksonville 62650  
Julian Buser  
6600 W. Main, Belleville 62223  
Theodore Grevas  
2701 17th St., Rock Island 61201  
Eugene T. Hoban  
6429 North Ave., Oak Park 60302  
Philip G. Thomsen  
13826 Lincoln, Dolton 60419  
Cyril C. Wiggishoff  
25 E. Washington, Chicago 60602

STAFF: Alexander R. Lerner

##### Responsibilities and Purposes:

The responsibilities of the Committee on Governmental Health Program Reimbursement will be to consider all problems of physician reimbursement by the government health programs—Medicare, Medicaid, MEDICHEK and CHAMPUS. The Committee serves on a stand-by basis.

#### POLICY COMMITTEE

##### Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

#### PUBLICATIONS COMMITTEE

and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

Allan L. Goslin, *Chairman*  
712 N. Bloomington, Streator 61364  
Lawrence Hirsch  
2434 W. Grace St., Chicago 60618  
Fred Z. White  
723 N. 2nd St., Chillicothe 61523  
STAFF: Perry Smithers

Jacob E. Reisch, *Chairman*  
1129 S. Second St., Springfield 62704  
Lawrence L. Hirsch  
2434 W. Grace St., Chicago 60618  
Alfred J. Kiessel  
1800 E. Lake Shore Dr., Decatur 62521  
Warren D. Tuttle  
203 N. Vine St., Harrisburg 62946  
Herman Wing  
155 N. Harbor Dr., Chicago 60601  
STAFF: Richard A. Ott

##### Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*

#### ADVISORY COMMITTEE TO ISMS AUXILIARY

J. M. Ingalls, *Chairman*  
502 Shaw Avenue, Paris 61944  
Robert T. Fox  
2136 Robin Crest Lane, Glenview 60025  
Joseph H. Skom  
707 Fairbanks Ct., Chicago 60611  
STAFF: Roger N. White

##### Responsibilities and Purposes:

The committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

#### COMMITTEE ON COMMITTEES

##### Responsibilities and Purposes:

The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

Joseph L. Bordenave, *Chairman*  
415 S. 2nd St., Geneva 60134  
Robert R. Hartman  
1515A Walnut St., Jacksonville 62650  
William M. Lees  
6518 N. Nokomis, Lincolnwood 60646  
STAFF: Perry Smithers



# Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

## COMMITTEE ON HEALTH PLANNING

B. Smith Hopkins, *Chairman*  
602 University, Urbana 61801  
T. C. Bunting  
321 West Washington, Pittsfield 62363  
Carl E. Clark  
225 Edward Street, Sycamore 60178  
Vincent A. Costanzo, Jr.  
7531 Stony Island Avenue, Chicago 60649  
Robert D. Dooley  
6 Oakbrook Club Drive, J-108, Oak Brook 60521  
Miller L. Henderson  
1215 North Alpine Road, Rockford 61107  
Charles J. Jannings  
301 N. W. 11th, Fairfield 62837  
Ervin E. Nichols  
1 East Wacker Drive, Suite 2700, Chicago 60601  
Anthony Raimondi  
3240 Lake Shore Dr., Chicago 60657

### CONSULTANT:

Philip G. Thomsen  
13826 Lincoln Avenue, Dolton 60419  
STAFF: Alexander R. Lerner

### Committee:

Task Force on Health Systems Agencies

### Responsibilities and Purposes:

The Committee has the responsibility of keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies.

## COMMITTEE ON DRUGS AND THERAPEUTICS

Arthur R. Marks, *Chairman*  
101 E. Center St., Fairfield 62837  
Andrew Krajec  
108 W. South St., West Salem 62476  
Richard H. Suhs  
1409 Stevenson Drive, Springfield 62703  
William T. Gogan  
7623 W. 63rd St., Summit 60501  
Vincent A. Costanzo, Jr.  
7531 S. Stony Island, Chicago 60649  
Norman J. Ehrlich  
111 N. Wabash Ave., Chicago 60602  
CONSULTANT:  
Louis Gdalmann, R.Ph.  
5418 S. East View Park, Chicago 60615

STAFF: Mrs. Pat Uznanski

### Responsibilities and Purposes:

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

## COMMITTEE ON INSURANCE

B. Franklin Lounsbury, *Chairman*  
707 N. Fairbanks Ct., Chicago 60611  
John L. Froiland  
5020 S. Lake Shore Dr., Chicago 60615  
William A. Henry  
2161 Greenbriar, Springfield 62704  
Lawrence Knox  
1200 N. East St., Olney 62450  
O. Howard Reichman  
280 Cottage Hill, Elmhurst 60126  
Charles Schlageter  
707 N. Fairbanks Ct., Chicago 60611  
CONSULTANTS:  
Alfred D. Clementi  
1320 Haddington, Palatine 60067  
David S. Fox  
826 E. 61st St., Chicago 60637  
Jacob E. Reisch  
1129 W. 2nd St., Springfield 62704

### EX-OFFICIO:

Phillip D. Boren  
South Plum St., Carmi 62821

STAFF: Perry L. Smithers

### Responsibilities and Purposes:

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax Qualified Retirement Program (Keogh Plan), Retirement Investment Program, Group Disability Program, Business Overhead Expense Insurance, Group Major Medical Program, Hospital Benefit Program, and Group Life Insurance. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

## PLANNING AND PRIORITIES COMMITTEE

George T. Wilkins, *Chairman*  
3165 Myrtle, Granite City 62040  
Joseph L. Bordenave  
415 South 2nd St., Geneva 60134  
William Dunn, Student  
7208 Harvard, Apt. 1A, Forest Park 60130  
David S. Fox  
826 E. 61st St., Chicago 60637  
Jack Gibbs  
175 South Main, Canton 61520  
Lawrence L. Hirsch  
2434 Grace, Chicago 60618  
Eugene P. Johnson  
P.O. Box 68, Casey 62420  
Lawrence Knox  
1200 N. East St., Olney 62450  
Fredric D. Lake  
999 Michigan, Evanston 60202  
Richard L. Landau  
950 E. 59th St., Chicago 60637  
Joseph Moles  
715 Lake St., Oak Park 60301  
K. Thomas Papreck, Resident  
2205 Lynnhaven, Springfield 62704

John J. Ring  
511 E. Hawley St., Mundelein 60060  
P. John Seward  
2400 N. Rockton, Rockford 61103  
Joseph C. Sherrick  
303 E. Superior, Chicago 60611  
Glen E. Tomlinson  
4 Lincoln Professional Park, Lincoln 62656  
Walter W. Whisler  
1753 W. Congress Pkwy., Chicago 60612

### CONSULTANTS:

J. M. Ingalls  
Joseph H. Skom

### Responsibilities and Purposes:

The President-Elect shall serve as the Chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

## HOUSE COMMITTEE ON REDISTRICTING

John J. Ring, *Chairman*  
511 E. Hawley St., Mundelein 60060  
Julian W. Buser  
6600 W. Main, Belleville 62223  
E. Newton DuPuy  
1842 Grove, Quincy 62301  
C. Larkin Flanagan  
505 N. Lake Shore, Chicago 60611  
Jere E. Freidheim  
3050 Wallace, Chicago 60616  
Aaron B. Gerber  
23450 Western, Park Forest 60466

Lawrence L. Hirsch  
2434 Grace St., Chicago 60618  
Wayne N. Leimbach  
1240 N. Highland, Aurora 60506  
Eugene T. Leonard  
Doctor's Park, 5670 E. State St., Rockford 61108  
Warren D. Tuttle  
203 N. Vine, Harrisburg 62946

### CONSULTANTS:

Fredric D. Lake  
999 Michigan, Evanston 60202  
J. M. Ingalls  
502 Shaw, Paris 61944

## TASK FORCE ON MANDATORY CONTINUING MEDICAL EDUCATION

Joseph C. Sherrick, *Chairman*  
303 E. Chicago Ave., Chicago 60611  
George Andrews  
Ex. Dir., Ill. Assoc. of Osteo. Physicians  
5206 S. University, Chicago 60615  
Dean Bordeaux  
221 N.E. Glen Oak Ave., Peoria 61636  
Norman Frank  
421 Park Ave., Clarendon Hills 60514

Jacob R. Suker  
303 E. Chicago Ave., Chicago 60611  
D. Dax Taylor  
SIU School of Medicine,  
801 N. Rutledge, Springfield 62707

### CONSULTANT:

C. Clarke Mangun, AMA  
535 N. Dearborn St., Chicago 60610

## STRATEGY COMMITTEE ON STATE GOVERNMENT

J. M. Ingalls, *Chairman*  
502 Shaw, Paris 61944  
Audley Connor  
3233 King Drive, Chicago 60616  
David Fox  
826 E. 61st, Chicago 60637  
Robert R. Hartman  
1515A W. Walnut, Jacksonville 62650  
John Holland  
2131 Lindsay, Springfield

Francis Howard  
1725 W. Harrison, Chicago 60612  
James M. Laidlaw  
104 W. Clark, Champaign 61820  
Willard C. Scrivner  
6600 W. Main, Belleville 62223  
George T. Wilkins  
3165 Myrtle Avenue, Granite City 62040  
STAFF: Roger N. White  
Don Udstuen



## TASK FORCE ON MEDICAL EXAMINER BILL

P. John Seward, *Chairman*  
2400 N. Rockton, Rockford 61101  
Donald Van Fossan  
800 E. Carpenter, Springfield 62702  
Seymour Glagov  
5233 S. University, Chicago  
Donal D. O'Sullivan  
203 Forest Avenue, Oak Park

Robert Stein  
2926 Arlington Avenue, Highland Park 60035

CONSULTANTS:  
Alfred J. Kiessel  
Joseph C. Sherrick

STAFF: R. Kjellander

## TASK FORCE ON HEALTH SYSTEMS AGENCIES

Philip G. Thomsen, *Chairman*  
13826 Lincoln Ave., Dolton 60419  
B. Smith Hopkins  
602 University, Urbana 61801  
David F. Rendleman  
10 Pinewood, Carbondale 62901

John J. Ring  
511 E. Hawley, Mundelein 60060  
Willard C. Scrivner  
6600 W. Main St., Suite 2, Belleville 62223  
Joseph H. Skom  
707 Fairbanks Ct., Chicago 60611  
STAFF: Alexander R. Lerner

## TASK FORCE ON PROFESSIONAL LIABILITY

Fredric D. Lake, *Chairman*  
Illinois State Medical Society  
999 Michigan Ave., Evanston 60202  
George Andrews, Exec. Dir.  
Ill. Assoc. Osteopathic Physicians  
900 E. Center St., Ottawa 61350  
Thomas Baffes  
Chgo. Surgical Society  
1701 Woodland St., Park Ridge 60068  
Phillip D. Boren  
ISMS  
South Plum St., Carmi 62821  
Joseph Caminiti  
Ill. Hosp. Assoc.  
1200 Jorie Blvd., Oak Brook 60521  
Clinton L. Compere  
Ill. Orthopaedic Society  
233 E. Erie, Chicago 60611  
George G. Curl  
Chgo. Urological Society  
715 Lake, Oak Park 60301  
David L. Doud  
Amer. College of Surgeons  
900 Franklin, Normal 61761  
Charles F. Downing  
Ill. Chap., Amer. College of Phys.  
1067 W. Main St., Decatur 62522  
Ward Eastman  
Ill. Surgical Society  
414 St. Mark's Court, Peoria 61303  
David S. Fox  
Chicago Medical Society  
826 E. 61st St., Chicago 60637  
Herb Gardner  
Ill. Hospital Assoc.  
1200 Jorie Blvd., Oak Brook 60521  
John P. Harrod, Jr.  
Amer. Coll. OB-GYN, Ill. Sec.  
2315 E. 93rd St., Chicago 60617  
Welland A. Hause  
Ill. Soc. of Pathologists  
St. Mary's Hospital, Decatur 62525  
Henri Havdala  
Ill. Soc. of Anesthesiologists  
Mt. Sinai Hospital, 2755 W. 15th St.,  
Chicago 60608

J. M. Ingalls  
ISMS  
502 Shaw Ave., Paris 61944  
Hushang Javid  
ISMS  
27 Royal Vale, Oak Brook 60521  
Harold Kirk  
Ill. Assoc. of Ophthalmology  
715 Lake St., Oak Park 60301  
Robert E. Knight  
Ill. Soc. of Ophth. & Otolaryngology  
6 Citizens Square, Normal 61761  
Harold Lasky  
Chicago Radiological Society  
55 E. Washington, Chicago 60612  
Alan E. Lasser  
Ill. Dermatological Soc., Inc.  
64 Old Orchard, Skokie 60076  
Robert Lindley  
Chicago Medical Society  
310 S. Michigan Ave., Chicago 60604  
Guy Matthew  
Ill. Radiological Society  
1753 W. Congress, Chicago 60612  
Peter McKinney  
Chicago Society of Plastic Surgery  
251 E. Chicago Ave., Suite 1029,  
Chicago 60611  
John McLaughlin  
Ill. OB-GYN Society  
2100 Glenwood, Joliet 60435  
Vera Morkovin  
Am. Coll. of Emergency Phys.  
Illinois Masonic Hospital,  
836 W. Wellington, Chicago 60657  
Ringaudas Nemickas  
Ill. Soc. of Internal Medicine  
2160 South First, Maywood 60153  
Robert O'Leary  
Illinois Hospital Association  
1200 Jorie Blvd., Oak Brook 60521  
Elliott Partridge  
ISMS  
1201 Pine, Eldorado 62930  
Clyde Phillips  
Cook County Phys. Assoc.  
841 E. 63rd St., Chicago 60637

Albert L. Pisani  
Ill. Chap., Amer. Academy Pediatrics  
40 South Clay Street, Hinsdale 60521  
Mark M. Pomaranc  
Ill. Chap., Amer. Coll. of Phys.  
175 Delaware Pl., Chicago 60611  
Karl Richardson  
Chicago Dental Society  
30 N. Michigan, Chicago 60602  
David Rothstein  
Ill. Psychiatric Society  
55 E. Washington St., Chicago 60602  
Carlo Scuderi  
Ill. Orthopaedic Society  
104 S. Michigan, Chicago 60603  
Joseph H. Skom  
ISMS  
707 Fairbanks Court, Chicago 60611  
Irwin A. Smith  
Ill. Academy of Family Phys.  
1141 Church Street, Northbrook 60062  
Thomas Starshak  
Ill. State Dental Society  
1940 W. Galena Blvd., Aurora 60506  
Thomas Szwed  
Ill. Assoc. Osteo. Phys. & Surgs.  
7775 W. Talcott, Chicago 60631  
Eugene Vickery  
ISMS  
202 S. Schuyler, Lena 61048  
Walter W. Whisler  
Ill. Neurosurgical Society  
1753 W. Congress Pkwy.,  
Chicago 60612  
Don Wood  
Chicago Hospital Council  
840 N. Lake Shore Dr., Chicago 60611  
LEGAL COUNSEL:  
Richard E. Favoriti  
Burditt & Calkins, 135 S. LaSalle St.,  
Chicago 60603  
CONSULTANTS:  
Joel Edelman  
R.R. #2, Richton Road, Crete 60417  
John Norris, American Health Systems  
215 Market St., San Francisco,  
Calif. 94105

# Other Appointments and Representatives

## REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Donald Stehr, *Chairman*  
102 E. Market, Havana 62644  
Albert G. Bledig  
1405 Locust, Eldorado 62930  
Jack Gibbs  
175 S. Main St., Canton 61520  
CONSULTANT:  
Jacob E. Reisch  
1129 S. 2nd St., Springfield 62704

STAFF: Perry L. Smithers

### Purpose:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

## INA-ISMS JOINT PRACTICE COMMITTEE

James E. Coeur  
630 Locust, Carthage 62321  
Robert M. Reardon  
1008 N. Main St., Bloomington 61701  
Fred Z. White  
723 N. 2nd St., Chillicothe 61523  
STAFF: Perry L. Smithers

### Responsibilities and Purposes:

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and

nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning, and (6) identify and address the ensuing problems related to basic role reorganization.

## ILLINOIS COOPERATIVE HEALTH DATA SYSTEMS

Philip D. Boren  
South Plum Street, Carmi 62821  
Audley F. Connor  
3233 S. King Drive, Chicago 60616  
Alexander Goldstein  
203 North Vine Street, Harrisburg 62946  
Allan L. Goslin  
712 North Bloomington, Streator 61364  
James A. McDonald  
515 Oakwood Drive, Geneva 60134  
Joseph R. O'Donnell  
444 Park Boulevard, Glen Ellyn 60137

Clifton L. Reeder  
734 North Merrill, Park Ridge 60068  
Richard Thurman, *Manager*  
Illinois Foundation for Medical Care  
55 East Monroe, Chicago 60603  
Fred Z. White  
723 North Second Street, Chillicothe 61523  
Roger N. White, *Executive Administrator*  
Illinois State Medical Society  
55 East Monroe, Chicago 60603  
Ben T. Williams  
Mercy Hospital, 1400 West Park, Urbana

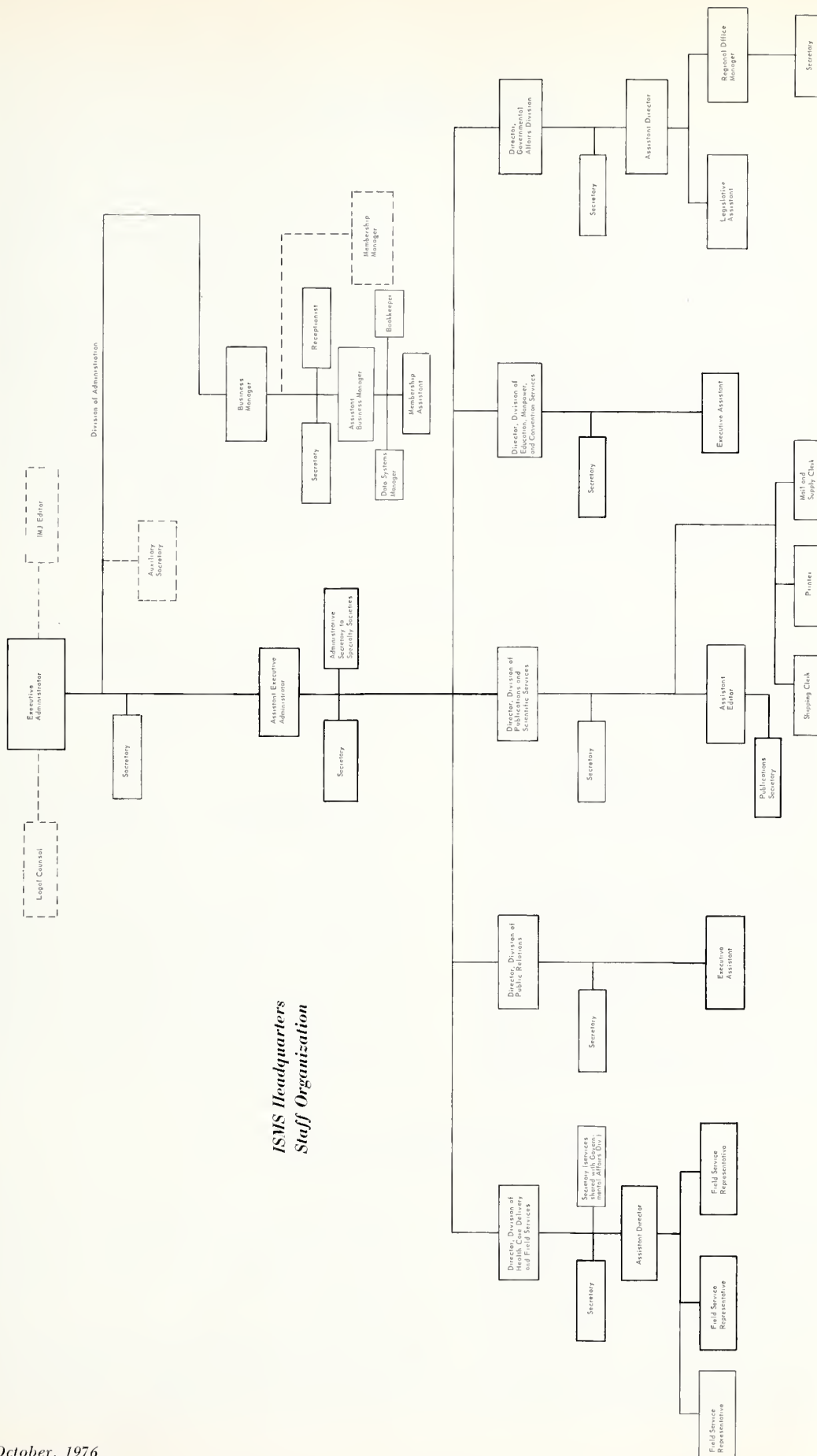
## OTHER REPRESENTATIVES

SWANBERG FOUNDATION, QUINCY  
Arkell M. Vaughn  
9012 S. Leavitt, Chicago 60620  
LIAISON TO ILL. SOC. OF THE AMER. ASSOC.  
OF MED. ASSTS.  
Carl E. Clark  
225 Edward St., Sycamore 60178  
Eli Borkon  
14 Pinewood, Carbondale 62901  
ILLINOIS COUNCIL OF HOME HEALTH AGENCIES  
Francis Bihss  
3 Powder Mill Rd., Belleville 62223  
CHICAGO ALLIANCE FOR VD AWARENESS  
Edward Piszczek  
6110 N. Leona, Chicago 60646  
DRUG ABUSE COUNCIL OF ILLINOIS  
George Shropshire  
1525 E. 53rd St., Chicago 60615  
Joseph Skom  
707 N. Fairbanks, Chicago 60611  
PEDIATRIC COORDINATING COUNCIL  
Daniel Pachman  
1212 N. Lake Shore, Chicago 60610  
ILLINOIS COALITION FOR HEALTH  
Richard E. Dukes  
Carle Clinic, Urbana 61801

ILL. INTERAGENCY COUN. ON SMOKING AND DISEASE  
Charles L. Swarts  
715 South Blvd., Oak Park 60302  
ILLINOIS MEDICAL RECORDS ASSOC.  
David T. Petty  
316 N. Michigan, Chicago 60601  
U.S. PHARMACOPOEIA  
Joseph Skom  
707 N. Fairbanks, Chicago 60611  
Arthur Marks, *Alternate*  
101 E. Center St., Fairfield 62837  
MD COMMITTEE ON OPTOMETRY  
Samuel Schall  
30 N. Michigan, Chicago 60602  
SCHOOL HEALTH PHYSICALS TASK FORCE—CHP  
Julius Kowalski  
436 Park Ave. East, Princeton 61356  
Charles J. Jannings, *Alternate*  
301 NW 11th, Fairfield 62837  
STATEWIDE COOPERATING ORGANIZATIONS OF THE  
COMMISSION ON CHILDREN  
Daniel Pachman  
1212 N. Lake Shore, Chicago 60610  
THE COUNCIL OF EMERGENCY CARE ORGANIZATIONS  
Max Klinghoffer  
127 E. Vallette, Elmhurst 60126  
ILLINOIS CANCER COUNCIL  
William M. Lees  
6518 N. Nokomis, Lincolnwood 60064



# ISMS Headquarters Staff Organization



# ISMS SERVICES

## Pursuit of Obligations

CONSTITUTIONAL PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 55 East Monroe St., Suite 3510, Chicago, and an office in Springfield at 520 S. Sixth St. Services of the Society, under the general supervision of Roger N. White, Executive Adminis-

trator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications, Medical Legal and Mental Health; Education, Manpower, and Convention Services; and Health Care Delivery and Field Services.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

Specific areas of responsibility and staff assignments will be identified to any member upon request.

## DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the Speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the

General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

The headquarters office has been organized by divisions to provide the membership of the Society with the best professional staff services available.

The Assistant Executive Administrator serves within this Division as a coordinator for programs of the state society. Further coordination between programs of the State Society and the County Medical Societies is achieved through Field Services Representatives.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

## DIVISION OF EDUCATION, MANPOWER AND CONVENTION SERVICES

The Division of Education and Manpower was established in response to the growing demands created by the rapid changes in the education and utilization of physicians and other health care personnel. A primary responsibility of the Division is to maintain information on the changes in medical education. The Division works in concert with the AMA in keeping abreast of changes in medical school curriculae, and in postgraduate medical education.

In addition, the Division attempts to maintain current information on the training and use of such ancillary

personnel as nurse practitioners and physician's assistants. New and innovative use of personnel are studied and recommendations made to the ISMS Board of Trustees as to their appropriateness and legality. All information maintained by the Division is, of course, available to all ISMS members.

The Division is responsible for matters of medical licensure examinations and issuance, and maintains liaison with the Department of Registration and Education to ensure that any licensure problems may be handled expeditiously.

A second major responsibility of the Division is the



administration of Insurance Programs sponsored by the Illinois State Medical Society. Included in these programs are a Major Medical and Excess Limits Major Medical programs, Group Life, Disability and Hospital Benefits Programs. The Division oversees the day to day operation of the programs, including the enrollment of new physicians. In addition the Division receives regular re-

ports on the programs outlining such information as the number of physicians enrolled in the program, amount of premium paid, amounts or money disbursed in claims settlements, etc.

The Division is also responsible for coordinating meetings and conventions for all divisions.

## GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically-related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

### Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legisla-

ture is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. The ISMS Public Affairs Committee strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

### Other Activities

The division also staffs the committees on Public Affairs, Eye Health, Ear, Nose and Throat, National Legislation, and Task Force on Medical Examiner Bill.

## DIVISION OF HEALTH CARE DELIVERY AND FIELD SERVICES

### Health Care Delivery

The Division of Health Care Delivery and Field Services has responsibility for keeping ISMS members abreast of socio-economic issues that have an impact on the delivery of health care.

The Division includes in its activities research on new health care programs being proposed or developed throughout the state. Such pertinent socio-economic information will be disseminated to the membership through articles in the *Illinois Medical Journal*, "Action Report," special educational programs developed by the Division and the Field Service.

The Division staffs the Council on Economics and Peer Review and its Committee on Peer Review Appeals. Principal duties of the Council concern relations with the health insurance industry and governmental health programs. The Peer Review Appeals Committee serves as the appellate body for all disputed cases initially considered by county and district peer review committees.

The Division staffs the Council on Social and Medical Services. The Council initiates and implements programs related to health education, medical facilities and services. It also maintains liaison with other health care organizations involved with vocational rehabilitation, aging, the poor, rural areas and emergency medical services. Committees of the Council include Aging, Health Care of the Poor and Rural Problems and Emergency and Disaster Care.

The Council on Environmental and Community Health and its Committee on Maternal Welfare cooperate with the Illinois Department of Public Health in the maintenance, protection and improvement of the health of the people of Illinois. Immunization programs, maternal wel-

fare and hypertension screening programs are examples of the areas of cooperation between ISMS and IDPH.

The Division has responsibility for the Council on Affiliate Societies, in order to enhance communications and liaison with the specialty organizations.

Additional division activities include the stand-by Committee on Governmental Health Program Reimbursement, which deals with Medicare, Medicaid, MEDICARE and CHAMPUS matters involving physician participation; and the Health Planning Committee, which closely follows the activities of the State Planning Agency, Statewide Health Coordinating Council, Illinois Health Facilities Planning Board and local Health Systems Agencies.

Staff of the Division attend meetings of governmental and professional organizations involved in the above described areas and participate in hearings and programs used to develop policy and programs regarding these issues.

### Field Services

The primary responsibility of Field Services is to provide liaison, service and education to the Society's membership through Field Service Representatives. Each Field Representative has the responsibility for liaison with component societies, allied professions and government agencies, to insure State Society representation and to provide a means for communication; service to the trustees, officers, executives, general membership and county medical societies; to provide a constant update on ISMS information, programs and resources; and education to the general membership through the distribution of a wide variety of issues affecting the practice of medicine. Specific areas of activity include health planning, President's Tour, Trustee District meetings, and the key-man program.

## DIVISION OF PUBLIC RELATIONS AND MEMBERSHIP SERVICES

The Division of Public Relations functions both as an outlet to the news media and as a source of information for the membership.

Staff members prepare speeches, slide presentations, pamphlets and other materials on a wide range of topics to support activities of officers, councils and committees. In addition, the Division arranges press conferences and prepares news releases to publicize ISMS actions and views on major issues. Also, the Division serves as liaison to the news media, responding to almost daily requests for background information or summaries of society activities.

Beyond these traditional public relations duties, the Division conducts a number of special, highly successful projects. Among them are:

*President's Tour* . . . takes the ISMS President to each Trustee District and provides an opportunity for members to discuss with the president matters affecting medicine and the society. An integral part of the "tour" is press conferences and media interviews as well as civic club speaking engagements arranged by the division.

*Action Report* . . . is an occasional newsletter which reports on ISMS activities and major events affecting medicine.

*Malpractice Report* . . . is a periodic newsletter designed to inform all Illinois physicians, dentists and hospital administrators of the latest malpractice developments and activities of the Task Force on Professional Liability. The Division also assists the Task Force in implementing special public relations and membership education projects.

*AID (Athletics . . . Injury and Disease)* . . . assists coaches and trainers in prevention, recognition and initial treatment of injuries and illnesses. This quarterly sports-medicine newsletter is distributed to approximately 2,000 junior and senior high school coaches and trainers in Illinois.

*Legislative Radio-TV Activities* . . . include programs throughout the state featuring a discussion by a physician and legislator of major health legislation pending in the General Assembly.

*Radio-TV Speaker's Bureau* . . . provides physicians to discuss general medical topics on regularly-scheduled programs. In addition, the bureau provides physician speakers for civic, fraternal, church and community groups.

*Public Service Radio Announcements* . . . providing general health information are distributed to more than 150 Illinois radio stations.

## DIVISION OF PUBLICATIONS, MEDICAL-LEGAL, AND MENTAL HEALTH

The Division of Publications, Medical-Legal and Mental Health is charged with staff responsibility for activities associated with the Council on Mental Health and Addiction, Medical Legal Council, and the Publications Committee. Under the councils are several committees and subcommittees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society.

### Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. Printing and duplicating services are furnished either through an in-plant shop or outside services through competitive bidding.

In addition, mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffer, and plate burning cabinet.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to

the practice of medicine. The editor welcomes suggestions for articles which may be of special interest to the membership. All members should consider the *IMJ* a means of communicating with fellow Illinois practitioners.

"Action Report" is an in-house publication totally produced in the ISMS print shop. Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS divisions to carry forth their mission, are produced.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

### Advertising

Commercial advertising is carried within the *Illinois Medical Journal*. The maintenance of the records of advertisers, insertion orders, contracts, and direct communication and liaison with advertising agencies and pharmaceutical houses fall within the purview of the division.

### Other Services

Liaison is maintained with many governmental and voluntary agencies to guarantee an awareness of current activities and to have medicine's voice heard. The division, in addition, attempts to have expert information available to the members.

## SPECIAL PUBLICATIONS

### Action Report

"Action Report" is an occasional newsletter published by the Illinois State Medical Society. It is distributed to members upon request. Purpose of the report is to alert physicians to important events or activities affecting the practice of medicine.

A short deadline ensures that important news is disseminated to the physicians as quickly as possible so that appropriate responses may be made.

### On the Legislative Scene

Emanating from the Springfield Regional Office

is a weekly newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request. It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in Springfield to specific bills and has alerted physicians to the need for involvement in public affairs.



## SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances by conducting postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharpe & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

2) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

3) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

4) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

## PHYSICIAN RECRUITMENT & STUDENT LOAN FUND PROGRAMS

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activi-

ties. First is its own Physician Recruitment Program & Doctor's Job Fair. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

### PHYSICIAN RECRUITMENT PROGRAM

The Physician Recruitment Program is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a physician.

More than 600 medical doctors have been placed through this program since its inception shortly after World War II.

The Physician Recruitment Program maintains an up-to-date listing of some 125 "open" areas needing physicians.

This service accepts requests from both physicians and communities for placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association and the Illinois Agricultural Association. Frequently, responsible

citizens or overburdened physicians in a community will contact the service.

Another important function of the Physician Recruitment Program is to assist small communities in developing programs to attract physicians such as the Doctor's Job Fair.

The Physician Recruitment Program sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics.

The Physician Recruitment Program offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society.

### ILLINOIS MEDICAL STUDENT LOAN FUND PROGRAM

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by a joint contribution from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans up to \$750 per semester for four years. The total amount of loan funds available varies from year to year, depending on repayments into the revolving fund. The amount of each individual loan is determined by the student's current financial need. Loan installments are made twice a year. A low interest rate is charged semi-annually from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fourth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties, but are denied matriculation

into medical school because their college grades or Medical College Admission Test (MCAT) scores are marginal. The board representing the sponsoring organizations of the program can recommend candidates annually to the University of Illinois College of Medicine. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town serving a rural population. Minimum practice time is:

(1) Freshman student receiving recommendation—five years of practice.

(2) Freshman student receiving financial assistance for four years—four years of practice.

(3) Upper classman already in medical school—one year of practice for each year that financial aid is taken (one year minimum).

ILLINOIS MEDICAL SOCIETY

The applicant may select a practice location of his own choice, provided it is in a community that has a demonstrated physician shortage. The choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities of Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; that he take a medical college admissions test; and that his college grade transcript be submitted

with the completed application form. Students applying to this program for a recommendation must complete an official application for admission to the University of Illinois by November 1. Illinois residency is required.

The board of the Medical Student Loan Fund Program conducts an annual interview meeting for those students who wish to enter medical school the following September. Students qualifying for the interview are notified and invited in mid-November. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, Manager, Medical Student Loan Fund Board, 1701 Towanda Ave., P.O. Box 2901, Bloomington, IL 61701.

## IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is evidence of a wide divergence of medical opinion in the case which is subject to litigation. The introduction of the IMT examiner and subsequent examination provides the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was established by the introduction of Illinois Supreme Court Rule 17-2 (subsequently renumbered 215-d) in September, 1961.

The Illinois State Medical Society played a sig-

nificant role in the creation and development of the IMT program. Impartial medical testimony in other states is limited to certain jurisdictions within the states.

The panel of impartial medical examiners is comprised of approximately 250 physicians who are grouped into medical specialties. Composition of the panel is reviewed periodically to maintain the highest standards for the courts of Illinois.

In 1976 the functions of IMT were expanded to provide service to the Supreme Court Attorney Registration and Discipline Commission.

The Illinois State Medical Society is appreciative of its role in offering, in conjunction with the Supreme Court, impartial testimony for the courts of Illinois. The Medical-Legal Council of the state society is charged with the responsibility of maintaining the IMT panel of qualified physicians.

## INSURANCE PROGRAMS

### Hospital Income Plan

The Hospital Benefit Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society derives no income from sponsorship.

The Plan pays \$25 in cash (Plan A) or \$50 in cash (Plan B) for each day the participant is confined to a hospital because of accident or illness for as long as one full year, up to \$9,125 (Plan A) or \$18,250 (Plan B) for each accident or sickness.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Robinson-Kirke Administrative Services, Inc., 209 S. LaSalle St., Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any other insurance policies members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital. Benefits are not taxable and, therefore need not be included in one's tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months

ending after the effective date of insurance. After two years from the effective date of insurance, coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: war or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

In summary, in 1971 the Hospital Benefit Plan was made available to the membership and was received very well. During enrollment periods all members regardless of age could participate. Enrollment periods are anticipated every 12 to 18 months.

### Group Disability Program

The Illinois State Medical Society's officially approved Group Disability Program is available to all eligible members of ISMS up to age 60 who are regularly attending all of the usual duties of their occupation and is renewable to age 70. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

The program is explained in detail in a brochure which is available by writing to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.



### Group Major Medical Expense Plan

A \$25,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has a 20% co-insurance feature and a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to \$100 a day and in addition up to \$150 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to \$2,000 for dependents. It will also cover a congenital abnormality from the first day of birth after the effective date of the contract up to \$2,000.

New members joining ISMS will be allowed to enroll without evidence of insurability or health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N.J., and is administered by Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076. Additional information may be obtained from the Illinois State Medical Society headquarters.

### Business Overhead Expense Group Plan

Today, more than ever, maintaining a medical

office is costly when one considers the increasing cost of rent, employee's salaries, accountant services, utilities, etc. The sole purpose of the Business Overhead Expense Group Plan is to step in and take care of overhead expenses during a period when the physician is totally disabled as a result of an accident or illness. In the event of a serious accident or illness, the physician can keep his office open and retain his personnel with the expenses being taken care of by the Business Overhead Expense Group Plan. This Program is not to be confused with the Group Disability Plan which provides an earned income for physician to meet his personal obligations for the maintenance of his home and family.

Monthly benefits are available up to \$3,500.00 with attractive premiums. Benefits commence on the first day provided total disability lasts one (1) month or longer. It will continue while totally disabled for as long as 24 months for any one accident or period of sickness. The premiums for this particular type of coverage constitute business expenses and are deductible under Internal Revenue Service Ruling (55-264, I.R.S. 1955-19, p. 8).

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60076.

### Personal Life Insurance Program

A guaranteed renewable term life insurance program, recommended by the Insurance Committee and approved by the Board of Trustees in 1972, is available to ISMS members in amounts ranging from \$10,000 to \$200,000. Features of the program include guaranteed future purchase options, guaranteed conversion privilege up to age 70, optional

family insurance benefits, double indemnity and disability waiver premium.

Dividends are applied against premiums and reduce member's cost.

For applications and further details, contact the administrator: A. W. Ormiston & Co., 175 W. Jackson Blvd., Chicago 60604; phone 312-922-3952.

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# Ancillary Organizations

## Illinois State Medical Society Auxiliary

### School Talk 1976-77

As the summer comes to an end and September signals the resumption of customary routines, Auxiliary officers, chairmen and members are busy preparing for the activities of the coming year. The national convention in Dallas last June was exciting. Illinois again won several awards for its contribution to the American Medical Association-Education and Research Foundation and the development of a new county society. This year we hope to build a more united, active auxiliary on this background.

To kick-off the year, auxiliaries from all over the state will gather in Peoria on September 28, 1976, for the Patchwork Symposium II. This workshop will focus on continuing education for the Auxiliary. Many educational and informative lessons are planned, including a legislative session, the presentation of project ideas by reporting officers and chairman, information about the Swine Flu Immunization Program, a demonstration by a CPR (cardio-pulmonary resuscitation) team, and discussion of media

and communications by a newspaper staff person. We will also have a chance to discuss new ideas and renew old friendships.

The goals which the Auxiliary has set for itself this year are many and varied. We want to increase our membership and involve more physician's spouses in our worthwhile activities. Therefore, we will begin a drive for potential members-at-large this fall. With an increased membership we will be able to provide stronger statewide support for the profession of medicine. We are aware that health care legislation is an on-going concern, particularly during this election year, and will attempt to educate the people in each of our communities about the need for legislation. This year the Auxiliary will also strive to become more knowledgeable of the health needs and facilities within our own communities. We want to learn about the facilities now available, how they can be improved and what other health care programs might be imple-

mented in the schools, in the area of safety, or in the care of the elderly and disabled. The Auxiliary can be a supportive and active arm of the medical profession by using our time and skills to improve the health care environment of each of our communities.

Finally the Auxiliary will continue to support the AMA-ERF project and our own benevolence program in Illinois. We hope to meet the precedent set in previous years by keeping the AMA-ERF shop open and selling items throughout the year.

One of the greatest challenges of being president is to communicate the message of auxiliary. I will be travelling throughout the state this year, visiting each county and bringing the message of a united auxiliary to our county membership. By enlarging Auxiliary friendships at the county level we can build a stronger organization. The support of each and every physician's spouse is welcomed and needed. I am looking forward to a full and stimulating year with you.

Mrs. John (Jane) Ovitz  
*President*

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# American Association of Medical Assistants Illinois Society

Membership in the Illinois Society, American Association of Medical Assistants is open to all persons employed by physicians in administrative and clinical categories. Membership includes medical assistants, office nurses, technicians, secretaries, bookkeepers, clerks and aides. The Society's objectives are to: (a) maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (b) assist the physicians in improving medical public relations; (c) bring into one association all medical assistant organizations of the state of Illinois; (d) provide an organization for those residing in Illinois counties where no medical assistant societies are organized; and (e) meet occasionally for interchange of ideas.

Membership is tri-level, structured similarly to that of the A.M.A.: medical assistants join together to form a county chapter, county chapters form the state society, and state societies form the national organization. There are active chapters in the following Illinois counties: Cook (Chicago, Cook County South, Aux Plaines, Southwest Suburban, and Northwest Cook), Coles-Cumberland, DuPage, DeKalb, Henry-Stark, Iroquois, Jefferson-Hamilton, Kane, Kankakee, LaSalle, Little Egypt-Williamson, Macon, McDonough, McHenry, McLean, Morgan-Scott, Perry, Peoria, Randolph, Rock Island, Sangamon, Shawnee, St. Clair, Spoon River Valley, Vermilion, and Will-Grundy.

Local county societies and the Illinois Society conduct numerous activities and professional education programs to educate and inform members. Major programs at the state level include: (1) "traveling courses" held throughout the state; (2) a symposium each September; (3) area meetings in conjunction with the ISMS President's Tour; (4) a three-day annual meeting in April; (5) publication of a newsletter, "Executive Memo", which keeps members up to date on AAMA activities; and (6) publication of a quarterly journal, *The Illini Cardinal*. Members are also entitled to the bi-monthly professional journal *The Professional Medical Assistant*, group insurance programs, as well as many other benefits through the AAMA. A national convention is held each year which includes programs of an educational nature. Members may also participate in a "home study" continuing education program utilizing audio cassettes and workbooks.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully completing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants certification program. For further information about this program write to the American Association of Medical Assistants, One East Wacker Drive, Suite 1510, Chicago 60601.

Contact the Illinois Society, AAMA President, Mrs. Jackson (see below) for membership information.

## OFFICERS

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## The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

- 1) The initiation of scientific and medical research activities.
- 2) The collection, evaluation and dissemination of the results of research activities to the public.
- 3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

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## Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill six purposes: (a) make readily available to all Illinois physicians CME programs that will enhance patient care; (b) catalog and co-ordinate existing programs to eliminate wasteful duplication; (c) encourage development of new CME methods, techniques, and systems; (d) help identify the learning needs of Illinois physicians; (e) seek out potential CME providers and serve as liaison between producers and consumers; and (f) encourage Illinois physicians to participate in formal CME programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee. The Illinois Association of Osteopathic Physicians & Surgeons also offers financial support for ICCME.

ICCME was officially chartered by the state as a non-profit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972.

ICCME is unique in three respects: (1) it is the only such organization supported by a state medical society and staffed by a full-time professional educator; (2) it unites the educational resources of the Illinois State Medical Society and the state's medical schools; and (3) independent in action, it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

### Current Major Activities:

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The fifth Congress meets April 15-16, 1977.

2. On behalf of ISMS, perform staff work for accreditation of intra-state CME.
3. Advise hospitals and other organizations on effective CME—both informally and through the "Illinois Hospital CME Consultation Service."
4. Organize workshops on techniques of CME—including an unusual "Workshop on CME Leadership" for leaders of hospital medical staffs and medical societies.
5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. For items now available, request our "CME Planning Aids Order Form."
6. Distribute *Your Personal Learning Plan*, a unique handbook offering advice on how to plan your learning most effectively; and *How to Start a CME Program in Your Hospital or Medical Society* for CME planners. All publications are free to Illinois physicians—M.D. or D.O.—upon request; just write the title on your prescription form and mail to ICCME, 55 E. Monroe, Chicago, IL 60603.
7. Co-ordinate a "Visiting Professor" Program on behalf of Illinois medical schools and other major medical centers.
8. Publish an *Illinois CME Case Compendium* for hospital CME case-discussion groups.
9. Publish a monthly calendar of Illinois CME activities for *IMJ*.

### Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: eight practicing physicians selected by the ISMS Board of Trustees; eight academic physicians, one selected by each dean of an Illinois medical or osteopathic school; plus the chairman of the ISMS Committee on CME Accreditation.



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# Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care is a physician-member, not-for-profit corporation established in July, 1971, at the request of the ISMS House of Delegates. Through the Foundation, physicians retain the prerogatives of medical determinations and have direct participation and leadership in the design, implementation and administration of various health care programs.

A total of ten foundations have affiliated with the Illinois Foundation: Chicago FMC, Crescent Counties FMC, East Central Illinois Foundation for Health Care, FMC of Central Illinois, Mid-State FMC, Northern Illinois FMC, Quad River FMC, Southern Illinois Medical Review Organization, Southwestern Illinois Medical Review Organization, and Western Illinois FMC. Now every area in the State has a regional foundation or review organization supported by and representative of the physicians in each of the regions in Illinois.

Since its implementation in February, 1972, the Hospital Admission and Surveillance Program (HASP), a program of the Foundation, has certified the medical necessity and length of stay for more than 1,100,000 Medicaid admissions as of June 30, 1976.

All but two of the affiliates administer HASP in their foundation areas. In addition, one of the affiliates, Northern Illinois FMC, holds commercial contracts to perform HASP-type review for major industries in its area.

The Foundation is also promoting, cooperatively with the local affiliates and the Illinois Hospital Association and its member hospitals, an all-patient (except for Medicaid patients who are reviewed by HASP) hospital review system—Physician Evaluation Educational Review System (PEERS). PEERS serves as a tool for review committees to evaluate the medical care rendered within their institution against their own established criteria, as well as against regional norms of practice. Since this program's inception in March, 1975, it has generated considerable interest among medical and hospital staffs.

Membership in Illinois FMC is available to any licensed physician or osteopath qualified to practice medicine in all its branches. In affiliated local foundation areas, Illinois FMC membership is contingent upon membership in the local FMC. Information can be obtained by writing IFMC, 55 East Monroe Street, Suite 3510, Chicago 60603.

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P.O. Box 68, Casey 62420

\*Robert J. Becker  
229 N. Hammes Ave., Joliet 60435

\*Richard L. Jensen, D.O.  
16250 S. Louis, South Holland 60473

\*Philip G. Thomsen  
13826 Lincoln, Dolton 60419

\*Warren D. Tuttle  
203 N. Vine St., Harrisburg 62946

Newell T. Braatlien  
635-10th Ave., Moline 61265

Andrew J. Brislen  
6060 South Drexel, Chicago 60637

C. Larkin Flanagan  
505 N. Lake Shore Dr., Chicago 60611

Miller L. Henderson  
1215 N. Alpine Rd., Rockford 61107

Frank J. Jirka, Jr.  
1507 Keystone, River Forest 60305

A. Beaumont Johnson  
860 E. Summit St., Elgin 60120

Lee Johnson  
P.O. Box 465 Litchfield 62056

Robert P. Johnson  
108 Maple Grove, Springfield 62707

William M. Lees  
6518 N. Nokomis, Lincolnwood 60646

Willard C. Scrivner  
6600 West Main, Belleville 62223

Maynard I. Shapiro  
7531 Stony Island, Chicago 60649

Allan M. Taylor  
1012 W. Fairchild, Danville 61832

Michael R. Treister  
1200 N. Ashland Ave., Chicago 60622

# Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Con-

gress. It cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 3510, 55 E. Monroe, Chicago 60603.

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## Illinois State Medical Insurance Services

Illinois State Medical Insurance Services is an Illinois corporation, formed in March, 1976, all of whose capital stock is owned by the Illinois State Medical Society. Its sole business is to act as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

Insurance Services provides all the management and underwriting services required for the operation of the insurance business of The Exchange. It does so under Power-of-Attorney granted it by The Exchange in a management agreement with an initial term of five years, and by each member of The Exchange through his application for membership. Under the Management Agreement the Board of Governors of The Exchange prescribes policy to be followed in the conduct of the business; within the guidelines established by these policy statements, Insurance Services manages the business of The Exchange, accepting or rejecting applications, determining the form of insurance policies, handling and disposing of claims, and performing all related functions. Insurance Services is compensated by The Exchange on the basis of expense reimbursement; it is not anticipated that Insurance Services will produce any operating profit.

The organization of Insurance Services comprises three

principal functional divisions: Risk Management and Underwriting, Claims, and Policyholder Services. Advisory and consultative services are provided by member physicians through a peer review system organized and directed by the Medical Director of Insurance Services. Financial and accounting services are provided by staff of the Illinois State Medical Society, whose Business Manager serves as Controller of Insurance Services. The offices of Illinois State Medical Insurance Services, Inc., are at 55 East Monroe Street, Chicago, Illinois 60603.

### Board of Directors

Joseph L. Bordenave  
Phillip D. Boren  
Alfred Clementi  
Robert T. Fox  
J. M. Ingalls  
Roger N. White

### Officers

Joseph L. Bordenave, *Chairman*  
Paul E. Singer, *President*  
Roger N. White, *Secretary-Treasurer*  
Phillip D. Boren, *Medical Director*

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## MEDICAL AND ALLIED HEALTH EDUCATION

### MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School

2020 W. Ogden Ave., Chicago, 60612

Northwestern University Medical School

303 E. Chicago Ave., Chicago, 60611

University of Chicago-Pritzker School of Medicine

950 E. 59th Street, Chicago 60637

University of Illinois College of Medicine

1853 W. Polk Street, Chicago, 60612

Abraham Lincoln School of Medicine, Chicago

Metropolitan Hospital Group, Chicago

Peoria School of Medicine, Peoria

Rockford School of Medicine, Rockford

School of Associated Medical Sciences, Chicago

School of Basic Medical Sciences, Chicago

School of Basic Medical Sciences, Urbana

Loyola University, Stritch School of Medicine

2160 S. First Ave., Maywood, 60153

Rush Medical College

1725 W. Harrison St., Chicago 60612

Southern Illinois University Medical School

801 N. Rutledge, P.O. 3926, Springfield, 62708



**ALLIED HEALTH EDUCATIONAL PROGRAMS**  
accredited by the  
**American Medical Association Council on Medical Education**

**ACCREDITED EDUCATIONAL PROGRAMS  
FOR LABORATORY ASSISTANT**

CHICAGO—Swedish Covenant Hospital  
V. A. West Side Hospital  
DANVILLE—St. Elizabeth Hospital  
ELGIN—Sherman Hospital  
OLNEY—Richland Memorial Hospital  
QUINCY—Blessing Hospital  
RIVER GROVE—Triton College

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
CYTOTECHNOLOGIST**

CHICAGO—Michael Reese Hospital & Medical Center  
Mt. Sinai Hospital Medical Center  
University of Chicago—Lying-in-Hospital

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
HISTOLOGIC TECHNICIAN**

CHICAGO—St. Joseph Hospital  
University of Chicago Hospital & Clinics  
Mercy Hospital & Medical Center  
Mount Sinai Hospital & Medical Center  
Holy Cross Hospital

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
MEDICAL ASSISTANTS**

BELLEVILLE—Belleville Area College  
CARTHAGE—Robert Morris School  
RIVER GROVE—Triton College

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
MEDICAL LABORATORY TECHNICIAN**

BELLEVILLE—Belleville Area College  
EAST PEORIA—Illinois Central College  
GODFREY—Lewis & Clark Community College

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
MEDICAL RECORD ADMINISTRATORS**

CHICAGO—University of Illinois College of Medicine  
NORMAL—Illinois State University

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
MEDICAL RECORD TECHNICIAN**

BELLEVILLE—Belleville Area College  
CHICAGO—Central YMCA Community College  
EAST PEORIA—Illinois Central College  
GRAYSLAKE—College of Lake County  
MORTON GROVE—Oakton Community College  
PALOS HILLS—Moraine Valley Community College

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
NUCLEAR MEDICINE TECHNOLOGY**

CHICAGO—Northwestern Memorial Hospital  
St. Mary of Nazareth Hospital Center  
EVANSTON—Evanston Hospital  
HINES—V. A. Hospital  
PARK RIDGE—Lutheran General Hospital  
RIVER GROVE—Triton College

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
OPERATING ROOM TECHNICIAN**

MOLINE—Moline Public Hospital  
PALOS HILLS—Moraine Valley Community College  
BELLEVILLE—Belleville Area College

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
OCCUPATIONAL THERAPIST**

CHICAGO—University of Illinois College of Medicine

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
PHYSICAL THERAPIST**

CHICAGO—Northwestern University Medical School  
University of Health Science/  
Chicago Medical School  
University of Illinois Hospital

**ACCREDITED EDUCATIONAL PROGRAMS FOR  
MEDICAL TECHNOLOGIST**

BELLEVILLE—St. Elizabeth Hospital  
BLUE ISLAND—St. Francis Hospital  
CHAMPAIGN—Burnham City Hospital  
CHICAGO—Augustana Hospital & Health Care Center  
Grant Hospital of Chicago  
Holy Cross Hospital  
Illinois Masonic Medical Center  
Louis A. Weiss Memorial Hospital  
Mercy Hospital & Medical Center  
Michael Reese Hospital & Medical Center  
Northwestern University Medical School  
Rush-Presbyterian-St. Luke's Medical Center  
St. Anne's Hospital  
St. Anthony Hospital  
St. Joseph Hospital  
St. Mary of Nazareth Hospital Center  
University of Illinois College of Medicine  
University of Health Sciences/  
Chicago Medical School  
V. A. Research Hospital  
DANVILLE—Lake View Memorial Hospital  
DECATUR—Decatur Memorial Hospital  
St. Mary's Hospital  
EVANSTON—Evanston Hospital  
FREEPORT—Freeport Memorial Hospital  
GENEVA—Community Hospital  
GREAT LAKES—U.S. Naval Hospital  
HINES—V.A. Hospital  
HINSDALE—Hinsdale Sanitarium & Hospital  
JOLIET—Silver Cross Hospital  
St. Joseph Hospital  
MAYWOOD—Foster G. McGaw Hosp./Loyola University  
OAK LAWN—Christ Community Hospital  
OAK PARK—West Suburban Hospital Association  
PARK RIDGE—Lutheran General Hospital  
PEORIA—Methodist Medical Center of Central Illinois  
St. Francis Hospital  
QUINCY—St. Mary's Hospital  
ROCKFORD—Rockford Memorial Hospital  
St. Anthony Hospital  
Swedish-American Hospital

SPRINGFIELD—St. John's Hospital  
Sangamon State University  
URBANA—Carle Foundation Hospital  
WAUKEGAN—St. Therese Hospital  
WINFIELD—Central DuPage Hospital

#### ACCREDITED EDUCATIONAL PROGRAMS FOR RADIOLOGIC TECHNOLOGIST

ARLINGTON HTS.—Northwest Community Hospital  
AURORA—Copley Memorial Hospital  
BELLEVILLE—Belleville Area College  
BLOOMINGTON—Bloomington Normal School of X-Ray  
Technology  
CENTRALIA—St. Mary's Hospital  
CHAMPAIGN—Parkland College  
CHICAGO—Central YMCA Community College  
Cook County Hospital  
DePaul University  
Henrotin Hospital  
Illinois Masonic Medical Center  
Louis A. Weiss Memorial Hospital  
Malcolm X Community College  
Michael Reese Hospital & Medical Center  
Mount Sinai Hospital & Medical Center  
Northwestern Memorial Hospital  
Provident Hospital & Training School  
Ravenswood Hospital Medical Center  
Roseland Community Hospital  
St. Anne's Hospital  
St. Joseph Hospital  
St. Mary of Nazareth Hospital Center  
South Chicago Community Hospital  
University of Illinois Hospital  
Woodlawn Hospital  
Wright Junior College  
DANVILLE—Lake View Memorial Hospital  
DECATUR—Decatur Memorial Hospital  
DIXON—Sauk Valley College  
EAST PEORIA—Illinois Central College  
ELGIN—St. Joseph Hospital  
EVANSTON—St. Francis Hospital  
GALESBURG—Carl Sandburg College  
GLEN ELLYN—College of DuPage  
GRAYSLAKE—College of Lake County  
HINSDALE—Hinsdale Sanitarium & Hospital  
KANKAKEE—Kankakee Community College  
KEWANEE—Kewanee Public Hospital  
MACOMB—McDonough District Hospital  
MALTA—Kishwaukee College  
MOLINE—Lutheran Hospital; Moline Public Hospital  
MORTON GROVE—Oakton Community College

OAK PARK—West Suburban Hospital Assn.  
OLNEY—Richland Memorial Hospital  
PALOS HILLS—Moraine Valley Community College  
PEORIA—St. Francis Hospital  
QUINCY—Blessing Hospital  
St. Mary's Hospital  
RIVER GROVE—Triton College  
ROCKFORD—Rockford Memorial Hospital  
Swedish American Hospital  
ROCK ISLAND—Rock Island Franciscan Hospital  
SOUTH HOLLAND—Thornton Community College  
SPRINGFIELD—Lincoln Land Community College  
Memorial Medical Center

#### ACCREDITED EDUCATIONAL PROGRAMS FOR RESPIRATORY THERAPIST

CHAMPAIGN—Parkland College  
CHICAGO—Cook County Hospital  
Central YMCA Community College  
Rush-Presbyterian-St. Luke's Medical Center  
Malcolm X College  
Northwestern University Medical School  
University of Chicago Hospitals & Clinics  
MOLINE—Lutheran Hospital  
PALOS HILLS—Moraine Valley Community College  
RIVER GROVE—Triton College  
ROCKFORD—St. Anthony Hospital  
SPRINGFIELD—Memorial Medical Center

#### ACCREDITED EDUCATIONAL PROGRAMS FOR RESPIRATORY THERAPY TECHNICIAN

CHAMPAIGN—Parkland College  
QUINCY—St. Mary's Hospital  
ROCKFORD—Swedish American Hospital  
SPRINGFIELD—St. John's Hospital

#### ACCREDITED EDUCATIONAL PROGRAMS FOR RADIATION THERAPY TECHNOLOGIST

CHICAGO—Rush-Presbyterian-St. Luke's Medical Center  
EVANSTON—Evanston Hospital  
HINES—V. A. Hospital

#### ACCREDITED EDUCATIONAL PROGRAMS FOR SPECIALIST IN BLOOD BANK TECHNOLOGY

CHICAGO—Mount Sinai Hospital & Medical Center  
University of Illinois College of Medicine  
SPRINGFIELD—St. John's Hospital  
PARK RIDGE—Lutheran General Hospital

### APPROVED SCHOOLS OF NURSING

#### Associate Degree Nursing Program

A coeducational nursing program under the auspices of a junior college, two years in length and leading to an Associate Degree in Nursing. The curriculum consists of arts and sciences at the junior college level and nursing theory closely coordinated with nursing practice, under direction and supervision of the college faculty, in community hospitals and health facilities.

Graduates, both men and women, are prepared to give patient-centered care in staff nurse positions in hospitals, nursing homes and similar situations. They are prepared to cooperate and to share responsibility for the patient's welfare with other members of the nursing and health staff, and to develop their own skills through experience as practicing nurses.



## General Entrance Requirements:

Good health.

High school graduation: with courses in biological and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units recommended).

Qualification for admission to the college and the nursing curriculum.

Cost: tuition in public supported junior colleges is low, in private colleges considerably higher. Add to this: fees, books, uniforms and maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

Belleville Area College  
Department of Nursing  
2500 Carlyle Road, Belleville 62221

Black Hawk College  
Department of Nursing  
6600—34th Avenue  
Moline 61265

College of Dupage  
Department of Nursing  
Lambert Rd. and 22nd  
Glen Ellyn 60137

Elgin Community College  
Department of Nursing  
1700 Spartan Drive  
Elgin 60120

Wm. R. Harper College  
Department of Nursing  
Algonquin & Roselle Road  
Palatine 60067

Illinois Central College  
Department of Nursing  
Box 2400  
E. Peoria 61635

Illinois Valley College  
Department of Nursing  
R.R. #1  
Oglesby 61348

Joliet Community College  
Department of Nursing  
1216 Houbolt Road  
Joliet 60436

Kankakee Community College  
Department of Nursing  
Box 888  
Kankakee 60901

Kaskaskia College  
Department of Nursing  
Shattuc Road  
Centralia 62801

Kennedy-King College  
Department of Nursing  
6800 S. Wentworth  
Chicago 60621

Lake County College  
Department of Nursing  
19351 Washington  
Grayslake 60030

Lewis & Clark Community College  
Department of Nursing  
Godfrey 62035

Lincolnland Community College  
Department of Nursing  
Shepherd Road  
Springfield 62703

Malcolm X. College  
Department of Nursing  
1900 W. Van Buren  
Chicago 60612

McHenry County College  
Department of Nursing  
6200 Northwest Highway  
Crystal Lake 60014

Morraine Valley Community College  
Department of Nursing  
10900 S. 88th Avenue  
Palos Hills 60465

Morton College  
Department of Nursing  
2500 S. Austin Blvd.  
Cicero 60650

Olive Harvey College  
Department of Nursing  
10001 S. Woodlawn  
Chicago 60628

Olney Central College of Eastern Illinois  
Department of Nursing  
305 North West St.  
Olney 62450

Parkland College  
Department of Nursing  
2400 Bradley  
Champaign 61820

Prairie State College  
Department of Nursing  
200 E. 197th St.  
Chicago Heights 60411

Rock Valley College  
Department of Nursing  
Rockford 61101

Carl Sandburg College  
Department of Nursing  
Box 1407  
Galesburg 61401

Sauk Valley College  
Department of Nursing  
River Campus, R.R. #1  
Dixon 61021

State Community College  
Department of Nursing  
417 Missouri Avenue  
East St. Louis 62201

So. Ill. Collegiate Common Market  
Associate Degree Nursing Program  
RR 2  
Carterville 62918

Southwest Community College  
Department of Nursing  
7900 S. Pulaski  
Chicago 60652

Harry S. Truman College  
Nursing Program  
1145 W. Wilson  
Chicago 60640

Thornton Community College  
Department of Nursing  
158 South State  
South Holland 60473

Triton College  
Department of Nursing  
2000 5th Avenue  
River Grove 60171

Waubensee Community College  
Department of Nursing  
Rt. 47 and Harter Road  
Box 508  
Sugar Grove 60554

## Baccalaureate Degree Nursing Program

Usually a coeducational nursing program under the auspices of a college or university, this is generally four academic or calendar years in length. The curriculum combines general education with nursing education, leading to the Bachelor of Science Degree in Nursing. Liberal education courses, such as arts and sciences, are shared with all college students. University medical centers and other related hospital and community health agencies are utilized for nursing theory and practice.

Graduates, both men and women, are prepared for beginning nursing positions in hospitals, nursing homes and community health services, and for advancement without further formal education to positions such as "nursing team" leader or head nurse. They also have the foundations for continuing personal and professional development and for graduate study and specialization in nursing.

### General Entrance Requirements:

Good health.

High school graduation: college preparatory program including biology and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units). Two years of a foreign language may be required. Meets college or university admission standard.

Cost: college or university tuition fees for nursing programs are comparable to those for other majors. Range in Illinois is from approximately \$1,000 to \$7,000 for tuition and fees for total program. Other expenses: books, uniforms, maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take state examination for licensure as a registered nurses ("R.N.").

† Bradley University  
Department of Nursing  
Peoria 61606

Brokaw Collegiate School of Nursing  
of Illinois Wesleyan University  
Bloomington 61701

Chicago State University  
Department of Nursing  
95th & King Drive  
Chicago 60628

†M DePaul University  
Department of Nursing  
2323 N. Seminary  
Chicago 60616

† Elmhurst College  
Department of Nursing  
190 Prospect Ave.  
Elmhurst 60126

Governors State University  
Park Forest South 60466

† Lewis College  
School of Nursing  
Route 53  
Lockport 60441

†M Loyola University  
School of Nursing  
6525 N. Sheridan  
Chicago 60626

† North Park College  
Department of Nursing  
5125 N. Spaulding  
Chicago 60625

†M Northern Illinois University  
Department of Nursing  
DeKalb 60115

† Olivet Nazarene College  
Department of Nursing  
Kankakee 60901

†M Rush College of Nursing & Allied Health Sciences  
1725 W. Harrison  
Chicago 60612

Sangamon State University  
Department of Nursing  
Shepherd Road  
Springfield 62703

†M St. Xavier College  
School of Nursing  
103rd and Central Park  
Chicago 60655

†M Southern Illinois University  
Division of Nursing  
Edwardsville 62025

†M University of Illinois  
College of Nursing  
845 S. Damen  
Chicago 60612

† Will admit RN students to generic baccalaureate nursing programs.  
M Offers masters program(s) in nursing

## Diploma (Hospital) Nursing Program

A nursing program under the auspices of a hospital or independent school of nursing, two to three years in length, and leading to a Diploma in Nursing. A college or university may provide some of the courses. The curriculum consists of theory and practice focused primarily on instruction and related clinical experience in the nursing care of patients in hospitals. Some liberal arts courses may be included.

Graduates, both men and women, have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be responsible for the direction of other members of the nursing team.

### General Entrance Requirements:

Good health.

High school graduation: Usually upper half of class, with courses in biological and physical sciences (1-2 units, one of which should be chemistry) and mathematics (1-2 units).

Satisfactory results on entrance tests and qualification for admission to the school.

Cost: \$900 to \$3,500; some include full maintenance.

Living Arrangements: Schools have residence facilities; many permit students to live at home if preferred.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

Augustana Hospital  
427 Dickens  
Chicago 60614

Blessing Hospital  
1005 Broadway  
Quincy 62301



Cook County School of Nursing  
1900 W. Polk St.  
Chicago 60612

Copley Memorial Hospital  
Weston and Lincoln  
Aurora 60507

Decatur Memorial Hospital  
2300 N. Edwards  
Decatur 62526

Evangelical School of Nursing  
4440 W. 95th St.  
Oak Lawn 60453

Evanston Hospital Nursing Program  
2351 W. Sherman  
Evanston 60201

Freeport Memorial Hospital  
1133 W. Stephenson  
Freeport 61032

Graham Hospital  
210 W. Walnut  
Canton 61520

Illinois Masonic Hospital  
836 Wellington  
Chicago 60657

Lake View Memorial Hospital  
812 N. Logan  
Danville 61832

Little Company of Mary Hospital  
2800 W. 95th St.  
Evergreen Park 60642

Lutheran General Hospital  
1700 Western Ave.  
Park Ridge 60068

Lutheran Hospital  
555—6th Street  
Moline 61265

Mennonite Hospital  
804 North East Street  
Bloomington 61701

Methodist Hospital  
221 N.E. Glen Oak  
Peoria 61603

Michael Reese Hospital  
2816 S. Ellis  
Chicago 60616

Moline Public Hospital  
635 Tenth Avenue  
Moline 61265

Northwestern Memorial Hospital  
250 E. Superior  
Chicago 60611

Passavant Memorial Hospital  
1600 Walnut St.  
Jacksonville 62650

Ravenswood Hospital  
4550 N. Winchester, P.O. Box 1319  
Chicago 60640

Rock Island Franciscan Hospital

School of Nursing  
767-30th Street  
Rock Island 61201

Rockford Memorial Hospital  
2400 N. Rockton  
Rockford 61103

St. Anne's Hospital  
4950 W. Thomas  
Chicago 60651

St. Anthony Hospital  
5658 E. State  
Rockford 61101

St. Francis Hospital  
319 Ridge  
Evanston 60202

St. Francis Hospital  
211 Greenleaf  
Peoria 61637

St. John's Hospital  
401 N. 9th St.  
Springfield 62701

St. Joseph's Hospital  
333 N. Madison  
Joliet 60435

St. Mary of Nazareth  
1127 N. Oakley  
Chicago 60622

South Chicago Community Hospital  
2320 E. 93rd St.  
Chicago 60617

Swedish-American Hospital  
2320 E. Charles St.  
Rockford 61101

West Suburban Hospital  
518 N. Austin Blvd.  
Oak Park 60302

## Practical Nursing Program

A coeducational nursing program under the auspices of public vocational education systems hospitals or community agencies, usually one year in length. The curriculum includes nursing theory coordinated with nursing practice.

Graduates, both men and women, of programs in practical nursing are prepared for two roles: (1) under the supervision of a professional nurse or physician, they give nursing care to patients in situations relatively free of scientific complexity; (2) in a close working relationship, they assist the professional nurse in giving care to patients requiring a high degree of nursing skill and judgment.

### Entrance Requirements:

Good health.

High school: Two years minimum, graduation desirable.

Junior and senior students who are currently enrolled in high school are eligible to enroll in the practical nursing program as part of their credit curriculum. Satisfactory results on entrance tests.

References and personal interview.

Cost: None under MDTA programs, to approximately \$400 plus maintenance.

Living Arrangements: Students usually live at home or in housing approved by school.

Graduate is eligible to take the state examination for licensure as a practical nurse ("L.P.N.").

Alton Vocational School  
School of Practical Nursing  
2200 College Ave.  
Alton 62002

Black Hawk College  
Practical Nursing Program  
6600—34th Avenue  
Moline 61269

- Bloomington School of Practical Nursing  
904 N. Roosevelt  
Bloomington 61701
- Chicago Public Schools  
Practical Nursing Program  
1820 W. Grenshaw  
Chicago 60612
- Health Occupations Careers  
Practical Nursing Program  
3901 S. State St.  
Chicago
- Danville School of Practical Nursing  
2000 E. Main St.  
Danville 61832
- Decatur School of Practical Nursing  
300 E. Eldorado  
Decatur 62523
- East St. Louis School of Practical Nursing  
1024 N. 2nd St.  
East St. Louis 62201
- Lake County College  
Practical Nursing Program  
19351 Washington  
Grayslake 60030
- Lake Land College  
Practical Nursing Program  
South Route #45  
Mattoon 61938
- Wm. Rainey Harper College  
Practical Nursing Program  
Algonquin & Roselle Roads  
Palatine 60067
- Highland College  
Practical Nursing Program  
Pearl City Road  
Freeport 61032
- Hinsdale Sanitarium & Hospital  
Nursing Program  
120 N. Oak St.  
Hinsdale 60521
- Illinois Central College  
Department of Nursing  
P.O. Box 2400  
East Peoria 61611
- Jacksonville Board of Education  
Practical Nursing Program  
504 E. Court  
Jacksonville 62650
- Joliet Township High School  
Practical Nursing Program  
201 E. Jefferson  
Joliet 60432
- Kankakee School of Practical Nursing  
Kankakee Community College  
P.O. Box 888  
Kankakee 60901
- Kishwaukee College  
Practical Nursing Program  
Malta Road  
Malta 60150
- John A. Logan College  
Practical Nursing Program  
Carterville 62918
- Oakton Community College  
Practical Nursing Program  
7900 N. Nagle  
Morton Grove 60053
- Parkland College  
Practical Nursing Program  
2400 W. Bradley  
Champaign 61820
- Quincy School of Practical Nursing  
820 Vermont St.  
Quincy 62301
- Rend Lake College  
Department of Nursing  
Box 1028  
Mt. Vernon 62846
- Rockford School of Practical Nursing  
5125-35th St.  
Rockford 61109
- St. Frances Cabrini  
School of Nursing  
811 S. Lytle  
Chicago 61607
- Carl Sandburg College  
Department of Nursing  
S. Lake Storey Rd., Box 1407  
Galesburg 61501
- Sauk Valley College  
Department of Nursing  
River Campus, Route #1  
Dixon 61021
- Shawnee Community College  
Department of Nursing  
Shawnee College Road  
Ullin 62988
- S. Eastern Ill. College  
Department of Nursing  
College Rd. Rt. 1  
Harrisburg 62946
- Spoon River College  
Practical Nursing Program  
102 E. Elm  
Canton 61520
- Springfield School of Practical Nursing  
1101 S. 15th St.  
Springfield 62703
- Thornton Community College  
Department of Nursing  
50 W. 162nd St.  
South Holland 60473
- Triton College  
Department of Nursing  
2000 N. 5th Avenue  
River Grove 60171
- Wabash Valley College  
Department of Nursing  
2200 College Drive  
Mt. Carmel 62863



# ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Repre-

sentatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

## EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for

four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They shall be elected at the general election in 1976 and 1978 and every four years thereafter.

## STATE OFFICERS

1976

*Governor*, DANIEL WALKER, Dem., Chicago  
*Lieutenant Governor*, NEIL F. HARTIGAN, Dem., Chicago  
*Secretary of State*, MICHAEL J. HOWLETT, Dem., Chicago  
*Comptroller*, GEORGE W. LINDBERG, Rep., Crystal Lake

*Treasurer*, ALAN DIXON, Dem., Belleville  
*Attorney General*, WILLIAM J. SCOTT, Rep., Evanston  
*Clerk of the Supreme Court*, JUSTIN TAFT, Rep., Rochester

## LEGISLATIVE BRANCH

### Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

### Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out

the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

### Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield 62701.

# DEPARTMENT OF CHILDREN AND FAMILY SERVICES

1026 South Damen Avenue, Chicago  
623 East Adams Street, Springfield  
Mary Lee Leahy, *Director*

## Director's Office

Dolores Reid, Deputy Director, Program Support Services  
David Bankard, Deputy Director, Management Services  
Neil Matlins, Deputy Director, Planning, Research and Evaluation  
Bill Ryan, Deputy Director, Program Operations  
Steve Bishop, Administrative Assistant to the Director (Chicago)  
Cheryl Kahn, Administrative Assistant to the Director (Springfield)  
Larry Rau, Legislative Liaison  
Sharon Garber, Ombudsman (Springfield)  
Reginald Patrick, Ombudsman (Chicago)

## Office of Community Relations

623 East Adams Street, Springfield  
Donald H. Schlosser, *Administrator*

## Office of Affirmative Action

2020 West Roosevelt Road, Chicago  
Rose Geter, *Administrator*

## Office of Guardianship

623 East Adams Street, Springfield  
Richard S. Laymon, *Guardianship Administrator*  
Carolyn W. Schaefer, *Assistant Guardianship Administrator*  
Patricia Everett, *Assistant Guardianship Administrator*,  
4302 North Main Street, Rockford

## Assistant Guardians

Jo Ann Cappellin, 4500 South Sixth Street Road, Springfield  
Effie M. Cox, 950 East 61st Street, Chicago  
Valerie F. Davis, 1439 South Michigan Avenue, Chicago  
Sylvia Flory, 48 West Galena Boulevard, Aurora  
Phillip Gorman, 4320 West Montrose, Chicago  
Gracie A. Herron, 2125 South First Street, Champaign  
William R. King, 5415 North University, Peoria  
Margarita Martinez, 1026 South Damen Avenue, Chicago  
William Perozzi, 10 Collinsville Avenue, East St. Louis  
Roberto Riadigos, 950 East 61st Street, Chicago  
Raul Torres, 4302 North Main Street, Rockford  
Leland E. Wright, 2209 West Main, Marion

## Program Services

### Office of Education and Rehabilitation Services

623 East Adams Street, Springfield  
Lee A. Iverson, *Administrator*  
Everett E. Hamilton, Funded Programs Consultant  
Farrell J. Mitchell, Residential Care Consultant  
Illinois Braille and Sight Saving School  
(Temporarily Vacant, Supt.) Jacksonville  
Illinois Children's Hospital-School  
(Paul Kavanaugh, Supt.),  
1950 West Roosevelt Road, Chicago  
Illinois School for the Deaf  
(Temporarily Vacant, Supt.) Jacksonville  
Illinois Soldiers' and Sailors' Children's School  
(Andrew J. Spelios, Supt.), Normal

Illinois Visually Handicapped Institute  
(Thomas Murphy, Supt.).  
1151 South Wood Street, Chicago  
Community Services for the Visually Handicapped  
(Peter R. Paul, Supt.),  
Room 1700, 160 North LaSalle Street, Chicago  
Herrick House Children's Center  
(Thomas P. Brennan, Administrator),  
West Bartlett Road, Bartlett  
Southern Illinois Children's Service Center  
(Mike Dolan, Administrator), Hurst

## Office of Child Development

623 East Adams Street, Springfield  
Thomas E. Villiger, *Administrator*  
2020 West Roosevelt Road, Chicago  
Carlton Williams, *Assistant Administrator*

## Program Operations

### Area Offices

Aurora, 48 West Galena Boulevard  
Champaign, 2125 South First Street  
Chicago East, 1439 South Michigan Avenue  
Chicago North, 4320 West Montrose  
Chicago South, 950 East 61st Street  
Chicago West, 1026 South Damen Avenue  
Decatur, 119 West William  
East St. Louis, 10 Collinsville Avenue  
Joliet, 58 North Chicago Street  
Marion, 2209 West Main Street  
Moline, 2810-41st Street  
Ottawa, 633 LaSalle Street  
Peoria, 5415 North University  
Quincy, 410 North Ninth Street  
Rockford, 4302 North Main Street  
Salem, 205 East Locust Street  
Springfield, 4500 South Sixth Street Road  
Waukegan, 4 South Genesee, Sixth Floor

## Management Services

### Financial Management

623 East Adams Street, Springfield  
Matthew J. Finnell, *Chief*

### Information Systems

623 East Adams Street, Springfield  
Mike Timko, *Chief*

### Central and Field Business Management

623 East Adams Street, Springfield  
Patricia Epperson, *Chief*

### Office of Manpower

623 East Adams Street, Springfield  
Thomas A. Nickell, *Administrative Assistant*

### Personnel Administration

623 East Adams Street, Springfield  
Don Hibma, *Chief Personnel Officer*

### Children's Financial Welfare

623 East Adams Street, Springfield  
Walter Meek, *Chief*

### Medical Services Unit

623 East Adams Street, Springfield  
Billie J. Prince, *Supervisor*



## DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706  
160 N. La Salle St., Chicago, 60601  
LeRoy P. Levitt, M.D., *Director*

### Office of the Director

Robert E. Lanier, Special Assistant  
Meyer Proctor, Chief, Office of Public Information  
Alan E. Grischke, Manager, Division of Legal Services  
William Fitzpatrick, Assistant Manager,  
Division of Legal Services  
George M. Skadden, Chief Auditor  
John Ryan, Legislative Liaison

### Management Services Administration

David Thomas, Administrator

### Division of Finance and Budgetary Services

Clarence W. Balthazor, Chief

### Division of Information Services

Charles R. Crawford, Chief

### Labor Relations Office

John O'Leary, Chief

### Facilities Planning and Operations Office

Joseph L. McGrath, Chief

### Operations Evaluation Office

Donald Carney, Chief

### Department of Personnel, Mental Health Field Services

John Meyer, Manager

### Division of Community Services

Robert Y. Anderson, Deputy Director

### Division of Developmental Disabilities

Richard E. Blanton, Ph.D., Deputy Director

### Developmental Disabilities Centers

A. L. Bowen Developmental Center, A. J. Schafter, Ph.D., Superintendent, Harrisburg 62946  
Dixon Developmental Center, David Edelson, Superintendent, Dixon 61021  
William W. Fox Developmental Center, Myron Birky, Superintendent, Dwight 60420  
William A. Howe Developmental Center, Arthur Dykstra, Jr., Superintendent, Tinley Park 60477  
Kankakee Developmental Center, Ira L. Collins, Superintendent, Kankakee 60901  
Lincoln Developmental Center, Paul Klockenga, Superintendent, Lincoln 62656  
Elisabeth Lunderman Developmental Center, Linda K. Gustafson, Ph.D., Superintendent, Park Forest 60466  
Warren G. Murray Developmental Center, Walter P. Plassman, M.D., Superintendent, Centralia 62801  
Waukegan Developmental Center, Patrick L. Saunders, Superintendent, Waukegan 60085  
Illinois Institute for Developmental Disabilities, Kenneth Swiatek, Ph.D., Acting Director, 1640 West Roosevelt Road, Chicago 60608

### Division of Clinical Services and Programs

Ivan Pavkovic, M.D., Deputy Director  
Division of Alcoholism, Mrs. Roalda J. Alderman, Superintendent  
Research Program Advisor, Peter Levison, Ph.D.  
Training Program Advisor, Matthew D. Parrish, M.D.

### Regions and Institutions

- 1A (ROCKFORD): Donald W. Hart, Administrator, H. Douglas Singer Mental Health Center, 4402 N. Main St., Rockford 61103  
H. DOUGLAS SINGER MENTAL HEALTH CENTER: Matthew D. Parrish, M.D., Superintendent, Rockford 61103  
1B (PEORIA): James G. Dalzell, Acting Administrator, George A. Zeller Mental Health Center, 5407 N. University, Peoria 61614  
GEORGE A. ZELLER MENTAL HEALTH CENTER, James G. Dalzell, Acting Superintendent, Peoria 61614  
EAST MOLINE MENTAL HEALTH CENTER: Konstantin Dimitri, M.D., Superintendent, East Moline 61244  
GALESBURG MENTAL HEALTH CENTER: Martin Cohen, Ph.D., Acting Superintendent, Galesburg 61401  
2 (CHICAGO): Prakash N. Desai, M.D., Administrator, 160 N. LaSalle St., Chicago 60601  
CHICAGO-READ MENTAL HEALTH CENTER: Peter T. Diamond, Ph.D., Superintendent, 6500 W. Irving Park Rd., Chicago 60634  
JOHN J. MADDEN MENTAL HEALTH CENTER: Robert deVito, M.D., Superintendent, 1200 S. First Ave., Hines 60141  
ELGIN MENTAL HEALTH CENTER: Robert J. Mackie, M.D., Superintendent, Elgin 60120  
MANTENO MENTAL HEALTH CENTER: Ella A. Curry, Superintendent, Manteno 60950  
TINLEY PARK MENTAL HEALTH CENTER: Jack Saporta, Ph.D., Superintendent, Tinley Park 60477  
3A (SPRINGFIELD): William H. Anderson, M.D., Administrator, Andrew McFarland Mental Health Center, 901 Southwind Rd., Springfield 62703  
ANDREW MCFARLAND MENTAL HEALTH CENTER: Ugo Formigoni, M.D., Superintendent, Springfield 62703  
JACKSONVILLE MENTAL HEALTH AND DEVELOPMENTAL HOSPITAL: William K. Murphy, Superintendent, Jacksonville 62650  
3B (DECATUR-CHAMPAIGN): Dale L. Kelton, Ph.D., Administrator, 2310 East Mound Rd., Decatur 62526  
ADOLF MEYER MENTAL HEALTH CENTER, Dale L. Kelton, Ph.D., Acting Superintendent, 2310 East Mound Rd., Decatur 62526  
4 (ALTON): Ivan Pavkovic, M.D., Administrator, Alton Mental Health Hospital, 4500 College Ave., Alton 62002  
ALTON MENTAL HEALTH HOSPITAL, Endrè Komlos, M.D., Medical Director; Joseph Gruber, M.D., Superintendent, Alton 62002  
CHESTER MENTAL HEALTH CENTER, Terry B. Brelje, Ph.D., Superintendent, Chester 62233

5 (CARBONDALE): Robert C. Steck, M.D., Administrator, Anna Mental Health and Developmental Hospital, Anna 62906

ILLINOIS MENTAL HEALTH INSTITUTES: Jack Weinberg, M.D., Director, 1601 West Taylor St., Chicago 60612

ILLINOIS STATE PSYCHIATRIC INSTITUTE: Jack Weinberg, M.D., Director, 1601 West Taylor St., Chicago 60612

INSTITUTE FOR JUVENILE RESEARCH: Frank T. Rafferty, M.D., Director, 907 S. Wolcott St., Chicago 60612

## STATUTORY BOARDS AND COUNCILS

### 1. Commission on Mental Health and Developmental Disabilities

Rose Poelvoorde, Silvis  
Michael Brady, Chicago  
Judy Buchanan, Bloomington  
Honorable Lee A. Daniels, Elmhurst  
Honorable Vince DeMuzio, Carlinville  
Honorable Joseph Fennessey, Ottawa  
Honorable Vivian Veach Hickey, Rockford  
Elizabeth Jacobs, Chicago  
Honorable Emil Jones, Jr., Chicago  
Honorable Edmund Kucharski, Chicago  
Honorable John R. Lauer, Broadwell  
Honorable Richard Mugalien, Barrington  
Honorable John J. Nimrod, Skokie  
Honorable Frank M. Ozinga, Evergreen Park  
Honorable Joseph Schneider, Chicago  
Honorable Esther Saperstein, Chicago  
Honorable Helen Satterthwaite, Champaign  
Honorable Jack Schaffer, Cary  
Helmut Stolle, Chicago  
Dr. Margaret Hastings, Springfield, *Staff Director*

### 2. Psychiatric Advisory Council

Roy R. Grinker, Sr., M.D., Chicago, *Chairman*  
LeRoy P. Levitt, M.D., Chicago  
George Pollock, M.D., Chicago  
Jack Weinberg, M.D., Chicago  
Jackson Smith, M.D., Hines

Harold M. Visotsky, M.D., Chicago  
Daniel X. Freedman, Chicago  
Ray Cunningham, M.D., Chicago  
Jan Fawcett, M.D., Chicago  
Frank T. Rafferty, M.D., Chicago  
Hyman Muslin, M.D., Chicago  
A. S. Norris, M.D., Springfield  
Marshall Falk, M.D., Chicago

### 3. Advisory Council—PL 88-164 Construction Grants

Hiram Sibley, Chicago, *Chairman*  
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Thomas P. DeGraffenried, M.D., DeKalb  
Mrs. John T. Even, Aurora  
Naomi Hielt, Springfield  
Georgi Jones, Springfield  
Joyce Lashof, M.D., Springfield  
Robert Norris, Evergreen Park  
Samuel A. Patch, Chicago  
Mrs. Wilbur F. Pell, Jr., Evanston  
Joseph H. Skom, M.D., Chicago  
Helmut Stolle, Chicago  
Thomas T. Tourlentes, M.D., Rock Island  
Mrs. Elbert Tourangeau, Hinsdale  
James L. Trainor, Chicago  
Bernice T. Van Der Vries, Evanston  
Harold Ziebell, Springfield

## NON-STATUTORY COUNCIL AND COMMITTEE

### 1. Citizens' Advisory Council on Alcoholism

James West, M.D., Chicago  
Fern Asma, M.D., Chicago  
Richard Decker, Decatur  
G. W. Grawey, M.D., Peoria  
La Verne Hawes, Chicago  
Dwight Patrick, Decatur  
James F. Griffin, Chicago  
John Keller, Park Ridge  
Paul B. Musgrove, Peoria  
James Oughton, Dwight  
W. David Steed, M.D., Oak Park  
Walter H. Gregg, Ph.D., Evanston  
William Thomas, M.D., Chicago  
Richard M. Sanders, Ph.D., Carbondale  
Joyce Lashof, M.D., Springfield  
Msgr. Ignatius McDermott, Chicago

### 2. Citizens' Advisory Council for Community Services

Arnold Levin, Ph.D., Chicago, *Chairman*  
Paul B. Musgrove, Peoria

Philip Carlson, Peoria  
Ralph Trask, Springfield  
William L. Mermis, Jr., Ph.D., Godfrey  
Margaret M. Hastings, Ph.D., Kenilworth  
Robert Norris, Evergreen Park  
Samuel A. Patch, Chicago  
Albert Bonilla, Chicago  
Honorable James Robinson, Danville  
Brockman Schumacher, Ph.D., Carbondale  
LeRoy P. Levitt, M.D., Chicago  
Lenora T. Cartright, Ph.D., Chicago  
Ivan Pavkovic, M.D., Springfield  
Richard E. Blanton, Ph.D., Springfield  
Robert Y. Anderson, Springfield  
Roalda J. Alderman, Chicago  
Augusta Claus, Springfield



## DANGEROUS DRUGS COMMISSION

The Drug Abuse Offense and Treatment Act of 1972 (PL 92-255) made federal funds available to the states for the purpose of combating drug abuse. In order to receive such funds, a state must submit a plan for implementing and evaluating an effective program for drug abuse prevention, treatment, and rehabilitation. Further, a single state agency must be established as the sole agency for the preparation and administration of the plan and allocation of funds.

The Dangerous Drugs Abuse Act, passed by the Illinois legislature in 1967, created the Dangerous Drugs Advisory Council. Pursuant to federal guidelines, the Act was amended in 1974 to establish the Dangerous Drugs Commission, designating it the single state agency to coordinate and administer drug abuse prevention, treatment and rehabilitation programs. The Commission works in cooperation with other state and federal agencies as well as public and private organizations. The Dangerous Drugs Advisory Council makes recommendations and advises the Commission in carrying out the state plan.

As the state planning agency for drug abuse functions, the Dangerous Drugs Commission is delegated the responsibility of developing and implementing an annual comprehensive state plan to reduce drug abuse and establish priorities in administering federal and state funds provided to support drug abuse programs.

In coordinating state and federal funding of drug abuse functions, the Commission is authorized to make grants-in-aid and purchase care agreements with both governmental and private agencies.

The Dangerous Drugs commission also licenses and regulates all drug treatment, education, prevention and rehabilitation programs in the state, except those conducted within a licensed hospital. The Commission sets treatment standards and issues rules and regulations for the operation of drug abuse programs.

Treatment modalities of programs receiving Dangerous Drugs Commission funds include methadone maintenance, both residential and out-patient; drug free residential and out-patient therapy, and hot-line and crisis referral services. In addition to treatment funding, the Dangerous Drugs Commission supports drug counselor training for previously drug dependent clients as well as clinical staff training.

Since reliable and timely data is essential in evaluating the effectiveness of drug abuse treatment and rehabilitation methods, the Information Services Division of the Commission continually collects, analyzes and applies data concerning clinical operations (medical workups, demographics) and regulatory methadone maintenance (counseling, toxicology, prescription dosages.) The division also keeps a weekly statewide log for methadone clinics, a continuing inventory of drug abuse program re-

sources, and a bank of research data on treatment modalities. All information is strictly confidential.

The Toxicology Division of the Dangerous Drugs Commission is the state laboratory facility which provides drug abuse tests to the state's total client population. The lab is subject to the regulations and standards set by the FDA, the National Institute of Drug Abuse and the Commission itself.

The Dangerous Drugs Commission is located at Marina City Office Building, 300 N. State St., Suite 1500, Chicago, 60610. Phone (312) 822-9860.

LeRoy P. Levitt, M.D., *Chairman*, Chicago  
Joseph Cronin, Springfield  
Patricia D. Craig, R.N., Marion  
Daniel X. Freedman, M.D., Chicago  
Harvey W. Johnson, Jr., Springfield  
Joyce Lashof, M.D., Chicago  
David M. Law, Washington  
Mary Lee Leahy, Springfield  
Charles Roche, Springfield  
James L. Trainor, Chicago  
Thomas Kirkpatrick, Jr., *Exec. Director*  
Marlene Nelson, Chicago

### Dangerous Drugs Advisory Council

Repr. L. Michael Getty, Dolton, *Chairman*  
William D. Barta, Waukegan  
Ronald Betz, R.Ph., Chicago  
David Blumenfeld, Esq., Chicago  
Murray C. Brown, M.D., Chicago  
Emanuel M. Cammonito, Esq., Blue Island  
Bernard Carey, Esq., Chicago  
Sen. John A. Davidson, Springfield  
Susan M. Barton-Gatlin, Springfield  
Norman Garfinkel, Oak Park  
Repr. Giddy Dyer, Hinsdale  
Naomi Hiett, Springfield  
Repr. George Hudson, Hinsdale  
Sam Lazich, Park Ridge  
Michael M. Mihm, Esq., Peoria  
Sen. Dawn Clark Netsch, Chicago  
Repr. William L. O'Daniel, Fairfield  
Robert W. O'Leary, Oak Brook  
Ron Pahl, Ph.D., Chicago  
Sen. James Philip, Downers Grove  
James M. Rochford, Chicago  
David B. Selig, Esq., Wilmette  
Joseph H. Skom, M.D., Chicago  
Ronald Stackler, Chicago  
Catherine Stokes, Chicago  
Jay Ulaneck, Chicago  
J. A. Wells, M.D., Maywood

## DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield  
James Trainor, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

### Administrative Staff

David L. Daniel, *Assistant Director*  
Robert G. Wessel, Chief Assistant to the Director  
Mr. Norman Ryan, Deputy Director, Division of Financial Management  
Mr. Jeffrey C. Miller, Deputy Director, Division of Medical Programs  
Mr. Jesse B. Harris, Deputy Director, Division of Programs & Services

### **Cook County Regional Offices**

#### **North Region (1-Cook County)**

Mrs. Vivian Sosin, Regional Director

#### **North Central Region (2-Cook County)**

Mr. James Patrick, Regional Director

#### **South Central Region (3-Cook County)**

Mrs. Wilda Mooney, Regional Director

#### **South Region (4-Cook County)**

Mrs. Edwyna Barnett, Regional Director

### **Downstate Regional Offices**

#### **Region 5 (Rockford)**

Mr. John A. Dotzel, Regional Director

#### **Region 6 (Peoria)**

Mr. Walter R. Bradbury, Regional Director

#### **Region 7 (Springfield)**

Miss Leona Franklin, Regional Director

#### **Region 8 (Marion)**

Mr. Lawrence E. Duff, Regional Director

### **Legislative Advisory Committee on Public Aid**

Senator Don A. Moore, Midlothian, *Chairman*

Representative Fred J. Smith, Chicago, *Vice-Chairman*

Joel Edelman, Crete, *Executive Director*

Senator Daniel Dougherty, Chicago

Senator Frank M. Ozinga, Evergreen Park

Senator Robert T. Lane, Chicago Heights

Senator Jack Schaffer, Crystal Lake

Representative Charles M. Campbell, Danville

Representative Susan Catania, Chicago

Representative Corneal A. Davis, Chicago

Representative Monroe L. Flinn, Cahokia

Representative William L. Kempiners, Joliet

Representative Robert E. Mann, Chicago

### **State Medical Advisory Committee**

Frederick Z. White, M.D., Chillicothe, *Chairman*

Louis Arp, Jr., M.D., Moline

Pedro A. Flores, M.D., Olympia Fields

Robert Ray Hartman, M.D., Jacksonville

F. Paul LaFata, M.D., Springfield, *Consultant*

George T. Mitchell, M.D., Marshall

Robert C. Muehrcke, M.D., Oak Park

Clyde W. Phillips, M.D., Chicago

Jacob E. Reisch, M.D., Springfield

Fred A. Tworoger, M.D., Chicago

Philip G. Thomsen, M.D., Dolton

### **Chiropractic Advisory Committee**

William Holmberg, DC, Rock Island

Paul M. Tullio, DC, Chicago

Leonard E. Fay, DC, Chicago

William H. Ownes, DC, Chicago

Harold G. Halterman, DC, Anna

William R. Dawson, DC, Alton

Gary Street, DC, Olney

Harold Haines, DC, Taylorville

Frank Eberhardt, DC, Springfield, *Consultant*

### **State Drug Advisory Committee**

Dave W. Watt, R.Ph., Springfield, *Chairman*

Harold J. Shinnick, R.Ph., Chicago

Louis Gdalmann, R.Ph., Chicago

Harold W. Pratt, R.Ph., Northbrook

Sherwood Thomas, R.Ph., Chicago

Myron Newman, R.Ph., Chicago

Russell Imblee, Jr., R.Ph., Mt. Carmel

Martin Alderman, R.Ph., Harvey

Herbert E. Braun, R.Ph., Chicago

M. Duane Dean, R.Ph., Kankakee

Cecil Dillard, R.Ph., Chicago

Bernard Evers, R.Ph., Collinsville

John K. H. Griffith, R.Ph., Springfield

Richard Hase, R.Ph., Anna

Eugene Ponder, R.Ph., Alton

Dale Bergstrom, R.Ph., Rockford

John Swain, R.Ph., Chicago

### **State Dental Advisory Committee**

John J. Byrne, D.D.S., Chicago, *Chairman*

James L. Buckner, D.D.S., Chicago

Bruce L. Douglas, D.D.S., Chicago

Vernon J. Haas, D.D.S., Bloomington

Bruno W. Kwapis, D.D.S., Belleville

H. B. Riley, D.D.S., Newton

William J. Rogers, D.D.S., Chicago

Harold H. Sitron, D.D.S., Chicago

John E. Zur, D.D.S., Chicago

### **State Optometric Advisory Committee**

Albert A. Bucar, O.D., Antioch

Richard G. Bursua, O.D., Marion

Thomas E. Desmond, O.D., East St. Louis

Albert J. Freedman, O.D., Rockford

Henry J. Luckhardt, O.D., Westmont

J. B. Stafford, O.D., Peoria

### **State Podiatry Advisory Committee**

John T. Baldwin, D.P.M., Kankakee

Fred G. Broun, D.P.M., Oak Park

Eugene Martin, D.P.M., Schaumburg

O. A. Mercado, D.P.M., Chicago

Raymond Turnley, D.P.M., Chicago

James Burton, D.P.M., Springfield

Jerome Mann, D.P.M., Arlington Hgts.

Edward Martin, D.P.M., Chicago

Ray Ward, D.P.M., Alton

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## **DEPARTMENT OF PUBLIC HEALTH**

535 West Jefferson St., Springfield 62706

Joyce C. Lashof, M.D., *Director*

Robert S. Gleason, *Legal Advisor*

Don Vance, *Legislative Liaison*

### **Office of Management Services**

Associate Director

Isabelle Crawford

Affirmative Action & Voluntary Resource

Dorothy Friedman

Budget and Fiscal Operation

George Akhurst



Education and Information Vital Records  
 Stan Miles  
 Electronic Data Processing  
 Thomas Stuckey  
 General Services  
 Joseph Schweska  
 Management Audit  
 Walter DeWeese  
 Public Health Laboratories  
 Richard A. Morrissey  
 State Center For Health Statistics  
 John Napier

#### **Office of Consumer Health Protection**

Associate Director  
 Leroy Stratton  
 Assistant State Sanitary Engineer  
 Michael Hines  
 Food and Drugs  
 Dr. Roy Upham  
 General Sanitation  
 Robert Wheatley  
 Milk Control  
 Harold McAvoy  
 Radiological Health  
 Phillip Brunner  
 Swimming Pools and Recreation  
 Jerry Ackerman  
 Nuclear Safety  
 Gary Wright

#### **Office of Health Facilities and Quality of Care**

Associate Director  
 Michael A. Werckle, M.D.  
 Assistant for Quality Review  
 Patricia Nolan, M.D.  
 Executive Assistant  
 James Yuill  
 Geriatric and Long Term Care Programs  
 William Irvine  
 Hospital, Laboratories & Acute Care  
 Michael Grobsmith  
 Development and Construction  
 Aden Clump  
 Planning and Conformance  
 George Lindsley  
 Ambulatory Care Review  
 Mary Beck  
 Curriculum Development  
 Beth J. Walston

#### **Office of Health Finance and Local Health**

Associate Director  
 Lowell Johnson

Audit Services Rate Review  
 James Handy  
 Research & Development  
 Ramsey Badre

#### **Office of Health Services and Local Health**

Associate Director  
 Allen Koplin, M.D.  
 Executive Assistants  
 Shirley Reed and Paul Wuellner  
 Dental Health  
 Bruce Douglas, D.D.S.  
 Disease Control and Communicable Disease  
 Byron J. Francis, M.D.  
 Poison Control  
 Al Grant  
 Renal Dialysis  
 Ruth Shriner  
 Tuberculosis Control  
 Al Grant  
 Venereal Disease Control  
 Robert Griffin  
 Veterinary Medicine  
 Russell Martin, D.V.M.  
 Family Health  
 Patricia Hunt, M.D.  
 Maternal & Child Care  
 Patricia Hunt, M.D.  
 MEDICHEK  
 Wesley J. Duiker  
 WIC  
 Patricia Fitzgerald  
 Vision and Hearing  
 Phil Shattuck  
 Emergency Medical Services and Highway Safety  
 Mohammed Ahkter, M.D.  
 Hemophilia  
 Ruth Shriner

#### **Regional Offices**

Region 1A 4302 North Main Street, Rockford 61103  
 Region 1B 5415 North University Ave., Peoria 61614  
 Region 2A 421 North County Farm Rd., Wheaton 60187  
 Region 3A 4500 South 6th St. Rd., Springfield 62706  
 Region 3B 2125 South 1st St., Champaign 61820  
 Region 4 Cottonwood Road, R.R. 4, Edwardsville 62025  
 Region 5 Rt. 3-2209 W. Main, Marion 62959

#### **Public Health Laboratories**

2121 West Taylor, Chicago, 60612  
 134 North 9th Street, Springfield 62706  
 P.O. Box 2467, Carbondale 62901

### **LOCAL HEALTH DEPARTMENTS**

**ADAMS COUNTY HEALTH DEPARTMENT**  
 Gene Mann, M.P.H., Public Health Administrator,  
 333 North Sixth Street, Quincy, 62301  
**\*BOND COUNTY HEALTH DEPARTMENT**  
 Carole Bone, R.N., Acting Administrator  
 107 W. College, Greenville, 62246  
**\*CALHOUN COUNTY HEALTH DEPARTMENT**  
 Margaret Hillen, R.N., Acting Administrator  
 Hardin, 62047  
**\*CHRISTIAN COUNTY HEALTH DEPARTMENT**  
 Clara J. Beaty, R.N., Acting Administrator  
 Court House, Taylorville, 62568

**CLAY COUNTY HEALTH DEPARTMENT**  
 Patricia L. Borah, R.N., Acting Administrator  
 104½ West Second Street, Flora, 62839

**COOK COUNTY DEPARTMENT OF PUBLIC HEALTH**  
 John B. Hall, M.D., M.P.H., Central Administrative Officer  
 1500 S. Maybrook Dr., Maywood, 60153

District Offices:  
 North—Des Plaines  
 South—Harvey  
 Southwest—Oak Lawn  
 West—Melrose Park

**COLES COUNTY HEALTH DEPARTMENT**

Fred Edgar

P.O. Box 604, Charleston, 61920

**DEKALB COUNTY HEALTH DEPARTMENT**

Richard B. Morgan, D.V.M., Public Health Administrator  
2337 Sycamore Road, DeKalb, 60115

**DEWITT-PIATT BI-COUNTY HEALTH DEPARTMENT**

Ruth Gregor, R.N., Acting Administrator

122 East Main Street, Clinton, 61727

Piatt County Office:

Court House, Monticello 61856

**DOUGLAS COUNTY HEALTH DEPARTMENT**

Mrs. Evelyn Henderson, R.N., Acting Administrator  
County Court House, Tuscola, 61953

**DUPAGE COUNTY HEALTH DEPARTMENT**

James P. Paulissen, M.D., M.P.H., Medical Officer  
111 N. County Farm Road, Wheaton, 60187

**EFFINGHAM COUNTY HEALTH DEPARTMENT**

Ted E. Crump, M.S., Public Health Administrator  
407 E. Jefferson St., Effingham, 62401

**EGYPTIAN HEALTH DEPARTMENT (Gallatin-Saline-White)**

Allen Kelly B.S., Public Health Administrator  
Route 45, Eldorado, 62930

County Offices:

White County—W. Main St., Route #1, Carmi, 62821

Gallatin County—Court House, Shawneetown, 62984

**FAYETTE COUNTY HEALTH DEPARTMENT**

Amanda Seston, R.N.

Fayette County Courthouse, Vandalia, 62471

**FRANKLIN-WILLIAMSON BI-COUNTY HEALTH DEPARTMENT**

Charles W. Elder, D.D.S., Public Health Administrator  
217 East Broadway, Johnston City, 62951

Franklin County Office:

226 North Main, Benton, 62812

**FULTON COUNTY HEALTH DEPARTMENT**

James Masters, M.P.H., Public Health Administrator  
502 North Main, Canton, 61520

Branch Office:

Main St., Astoria

**\*GREENE COUNTY HEALTH DEPARTMENT**

Barbara Cook, R.N., Acting Administrator  
419 N. Main, Carrollton, 62016

**\*GRUNDY COUNTY HEALTH DEPARTMENT**

Mary C. Reed, R.N., B.S., Public Health Admin.  
1340 Edwards Street, Morris, 60540

**\*HENRY COUNTY HEALTH DEPARTMENT**

Grace Van Vooren, R.N., Acting Administrator  
Court House Annex, Cambridge, 61238

**\*IROQUOIS COUNTY HEALTH DEPARTMENT**

Nancy Zumwalt, R.N., Acting Administrator  
123 N. Eighth, Watseka, 60970

**JACKSON COUNTY HEALTH DEPARTMENT**

John B. Amadio, Ph.D., Public Health Administrator  
342A North Street, Murphysboro, 62966

**JASPER COUNTY HEALTH DEPARTMENT**

Inez Holiday, Acting Administrator

113 S. Jackson, Newton, 62248

**\*JERSEY COUNTY HEALTH DEPARTMENT**

Nola Kramer, R.N., Acting Administrator  
301 S. Jefferson, P.O. Box 69, Jerseyville 62052

**JO DAVIESS COUNTY HEALTH DEPARTMENT**

Ronald F. Neu, M.P.H., Acting Public Health Admin.

311 South Main Street, Galena, 61036

**KENDALL COUNTY HEALTH DEPARTMENT**

Ruth Ann Little, R.N., Acting Administrator

Kendall Co. Office Bldg., P.O. Box 549, Yorkville, 60560

**LAKE COUNTY HEALTH DEPARTMENT**

Steven R. Potsic, M.D., M.P.H., Medical Officer  
3010 Grand Avenue, Waukegan, 60085

**LAWRENCE COUNTY HEALTH DEPARTMENT**

Maxine Jackman, R.N., Public Health Administrator  
Court House, Lawrenceville, 62439

**LEE COUNTY HEALTH DEPARTMENT**

Kenneth D. Ring, M.P.H., Acting Administrator  
144 N. Court, Dixon, 61021

**\*LIVINGSTON COUNTY HEALTH DEPARTMENT**

Gladys Kohrt, R.N., Acting Administrator  
Convalescent Center Building, R.R. 4, Pontiac, 61764

**LOGAN COUNTY HEALTH DEPARTMENT**

Thomas W. Oas, B.S., Acting Public Health Administrator  
128 Pine Street, Lincoln, 62656

**MCDONOUGH COUNTY HEALTH DEPARTMENT**

Marco Monti, M.P.H., Public Health Administrator  
531 E. Grant St., Macomb, 61455

**\*MCHENRY COUNTY HEALTH DEPARTMENT**

Richard A. Wissell, M.P.H., Public Health Administrator  
2200 N. Seminary Avenue, Woodstock, 60098

**MCLEAN COUNTY HEALTH DEPARTMENT**

E. E. Diddams, M.S.P.H., Public Health Administrator  
401 West Virginia Avenue, Normal, 61761

**MACON COUNTY HEALTH DEPARTMENT**

Robert E. Shrout, M.A., Public Health Administrator  
1085 South Main Street, Decatur, 62521

**\*MENARD COUNTY HEALTH DEPARTMENT**

Charles Mertz, Acting Administrator  
809 Old Salem Road, Petersburg, 62675

**\*MONROE COUNTY HEALTH DEPARTMENT**

Mary Kruse, R.N., Acting Administrator  
224 E. 3rd Street, Waterloo, 62298

**MONTGOMERY COUNTY HEALTH DEPARTMENT**

C. Tom Larson, B.S., M.H.A., Public Health Administrator  
200 South Main Street, Hillsboro, 62049

**MORGAN COUNTY HEALTH DEPARTMENT**

William D. Meyer, B.S., Public Health Administrator  
446 E. State Street, Jacksonville, 62650

**\*OGLE COUNTY HEALTH DEPARTMENT**

David Stevens, D.V.M., Acting Administrator  
106 South Fifth Street, Oregon, 61061



PEORIA COUNTY HEALTH DEPARTMENT  
Harold H. Rohrer, M.D., M.P.H., Director  
2116 North Sheridan Road, Peoria 61604

\*PIKE COUNTY HEALTH DEPARTMENT  
Mrs. Martha Lowry, R.N., Acting Administrator  
216 North Monroe, Pittsfield, 62363

QUADRI-COUNTY HEALTH DEPARTMENT  
John S. Pickle, MSEH, Acting Administrator  
Golconda, 62938

Massac County Office:  
Court House, Metropolis, 62960  
Johnson County Office:  
Vienna, 62995  
Hardin County Office:  
Gross Building, Elizabethtown, 62931

\*RANDOLPH COUNTY HEALTH DEPARTMENT  
Dereth Gehlausen, R.N., Acting Administrator  
P.O. Box 590, Chester 62233

\*ROCK ISLAND COUNTY HEALTH DEPARTMENT  
Fred J. Siebenmann, Jr., B.S., Public Health Admin.  
2116 25 Ave., Rock Island, 61201

SHELBY COUNTY HEALTH DEPARTMENT  
Elisabeth Holkenbrink, B.A., Public Health Administrator  
123 North Broadway, Shelbyville, 62565

STEPHENSON COUNTY HEALTH DEPARTMENT  
Arlo J. Anderson, B.S., Public Health Administrator  
12 North Galena Avenue, Freeport, 61032

TAZEWELL COUNTY HEALTH DEPARTMENT  
Gordon J. Poquette, M.P.H., Public Health Administrator  
1505 Valle Vista, Pekin, 61554

TRI-COUNTY HEALTH DEPARTMENT  
John S. Pickle, MSEH, Acting Administrator  
529 Cross Street, Cairo, 62914  
Union County Office:  
Jonesboro, 62952

VERMILION COUNTY HEALTH DEPARTMENT  
Stephen E. Laker, B.S., Acting Administrator  
808 North Logan, Danville, 61832

WABASH COUNTY HEALTH DEPARTMENT  
Alice B. Alford, R.N., Acting Administrator  
Court House, Mt. Carmel, 62863

\*WHITESIDE COUNTY HEALTH DEPARTMENT  
James M. Ryder, B.S., M.P.H., Acting Administrator  
Route 2, Morrison 61270

WILL COUNTY HEALTH DEPARTMENT  
James C. Barringer, B.S., Public Health Adm.  
501 Ella Avenue, Joliet, 60433

WINNEBAGO COUNTY DEPARTMENT OF PUBLIC HEALTH  
Joseph Orthoefer, D.V.M., M.P.H.,  
Public Health Administrator  
401 Division St., Rockford, 61108

#### Urban Health Departments

\*Berwyn Health Department  
J. V. Pelech, M.D., Health Director  
6600 West 26th Street, Berwyn, 60402

\*\*Champaign-Urbana Public Health District  
Gale Fella, M.P.H., Public Health Administrator  
505 South Fifth Street, Champaign, 61820

Chicago Health Department  
Murray C. Brown, M.D., Commissioner of Health  
Chicago Civic Center, Room 219, Chicago, 60602

\*\*East Side Health District  
Mani K. Sashankar, M.D., Dr.P.H., Director  
638 North 20th Street, East St. Louis, 62205

Evanston-North Shore Health Department  
William J. Hixon, M.S., Public Health Administrator  
1806 Maple Avenue, Evanston, 60201

Hygienic Institute  
Arlington Ailes, M.P.H., Public Health Admin.  
LaSalle, 61301

Oak Park Department of Public Health  
James D. Tills, Ph.D., M.P.H., Acting Director  
1 Village Hall Plaza, Oak Park 60303

Skokie Health Department  
Samuel L. Andelman, M.D., M.P.H., Director of Health  
8031 Floral Street, Skokie, 60076

Springfield City Health Department  
James Diekroeger, M.P.H., Public Health Administrator  
1415 E. Jefferson, Springfield 62703

\*\*Stickney Township Public Health District  
Kenneth Rehnquist, Acting Public Health Director  
5635 State Road, Burbank, P.O. 60459

*\*Limited Services*  
*\*\*Organized under the Coleman Act*

#### STATUTORY BOARDS AND COMMISSIONS (Allied with Public Health Operations)

##### Long-Term Care Facility Advisory Board

Robert Johnson, M.D., Springfield  
June Yeske, Bloomington  
Leon Shlofrock, Chicago  
Michael N. Fleming, R.N., Franklin Grove  
Catherine L. Roe, Lewistown  
C. F. Kerchner, Fairfield  
Herbert M. Krauss, Evanston  
Morton A. Lieberman, Ph.D., Chicago

Glenda Ashley, M.D., Chicago  
Ray Unterbrink, Springfield  
Marian L. Ascoli, Urbana  
Allan Roney, Springfield  
Patrick Ward, Springfield  
Bill Colp, Carbondale  
Hugh Canaday, Springfield, *ex-officio*  
Robert Lanier, Springfield, *ex-officio*  
Ross Richardson, Springfield, *ex-officio*

### **Hazardous Substances Advisory Council**

Richard C. Reinke, Lemont  
Edward F. O'Toole, Chicago  
Ken Cole, Chicago  
Michael R. Yates, Chicago  
Harvey Kravitz, M.D., Morton Grove  
Mrs. Jiffy Johnson, Springfield

### **Advisory Hospital Council**

Robert E. Lanier, Springfield  
Robert G. Wessel, Springfield  
John W. Rice, Chicago  
George C. Phillips, Jr., Springfield  
Murray Berg, Chicago  
Robert M. Magnuson, Elmhurst  
Fredric D. Lake, M.D., Evanston  
David S. Forkosh, M.D., Chicago  
Daniel K. Bloomfield, M.D., Urbana  
Andrew J. Griffin, M.D., Chicago  
Francis Bihss, M.D., Belleville  
Mrs. Louise M. Eggert, Oak Lawn  
Miss Margaret Cassin, East St. Louis  
Mrs. Nancy B. Jefferson, Chicago  
Lee Pravatiner, Chicago  
Mrs. Susan Bandlow Gende, Moline  
Ms. Hilda E. Frontany, Chicago  
James P. Streitz, Danville  
Vera Fina, Riverside  
Bruce Blomstron, Evanston  
Larry Bullock, Chicago  
Mrs. Georgia Gleason, Marseilles  
Geoffrey H. Raymond, Oak Park

### **Ambulatory Surgical Treatment Center Licensing Board**

Gwendolyn Boyd Schmidt, M.D., Chicago, *Chairman*  
E. Wynn Presson, Rockford  
James E. Coeur, M.D., Carthage  
Edward Jessee Jacobs, M.D., Arlington Heights  
Robert L. Ewbank, D.D.S., Danville  
Marion Etten, R.N., B.S.N., M.N.A., Chicago  
Ruth Sural, Chicago

### **Clinical Laboratory and Blood Bank Advisory Board**

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Wayne N. Leimbach, M.D., Aurora  
Mrs. Dorothea M. Prevo, M.S., Glencoe  
Hugh J. McDonald, Sc.D., Skokie

### **Hospital Licensing Board**

Jack B. Edmundson, Carbondale  
Theodor L. Jacobsen, Park Ridge  
Sister Ann Bailey, Decatur  
Robert E. Lanier, Springfield  
John J. Serpico, Chicago  
Jacquelyne D. Grimshaw, Chicago  
Elmer E. Abrahamson, Chicago  
Harry D. Conkey II, Mendota  
Adeline M. Jorstad, R.N., Plainfield  
Rosemary Laubenthal, R.N., Chicago  
William M. Lees, M.D., Lincolnwood

### **Migrant Labor Advisory Committee**

Harold Hartley, Centralia  
Naomi Hiett, Springfield  
Dean Sears, Bloomington  
Robert Munoz, Chicago  
Arthur Gottschalk, Flossmoor  
Helen Kaufman, Hooperston

Jorge Prieto, M.D., Evanston  
Don Ahrens, Narvard  
Henry Bol, Woodstock

### **Radiation Protection Advisory Council**

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Jerome J. Steerman, Urbana  
Kenneth H. Schnepp, M.D., Springfield  
Seymour Yale, D.D.S., Chicago  
F. E. Demaree, Chicago  
Kenneth W. Holland, Springfield, *ex-officio*  
John Rust, D.V.M., Chicago  
Marvin S. Lieberman, Springfield, *ex-officio*  
Lawrence Levin

### **Illinois Chronic Renal Disease Advisory Committee**

Joyce C. Lashof, M.D., Springfield, *Chairman*  
Arthur E. Abney, Chicago  
Edmund J. Lewis, M.D., Chicago  
David P. Earle, M.D., Chicago, *Consultant*  
Alan Kanter, M.D., Chicago  
Robert M. Kark, M.D., Chicago, *Consultant*  
Robert H. Pflederer, M.D., Peoria  
Franklin D. Schwartz, M.D., Chicago  
George Dunea, M.D., Chicago  
Charles Z. Hoffing, Oak Brook  
Alan G. Birtch, M.D., Springfield  
Olga Jonasson, M.D., Chicago  
Dean Stanley, Chicago  
Gabriel A. Stoll  
Ewald T. Sorenson, M.D., Rockford  
Harold Schwartz, Lincolnwood  
Richard Bilinsky, M.D., Springfield

### **Immunization Advisory Committee**

Mark Lepper, M.D., Chicago, *Chairman*  
John B. Hall, M.D., Chicago  
Joseph R. Kraft, M.D., Chicago  
David Greeley, M.D., Chicago  
John Holland, M.D., Springfield  
Byron J. Francis, M.D., Springfield, *Technical Secretary*  
James P. Paulissen, M.D., Wheaton  
Daniel J. Pachman, M.D., Chicago  
Patricia A. Hunt, M.D., Springfield, *Staff*

### **Health Facilities Planning Board**

Jack T. Knuepfer, Elmhurst, *Chairman*  
Philip C. Chinn, Wheaton  
Cornelia West Foley, Rockford  
Donovan F. Gardner, Pontiac  
Nancy B. Jefferson, Chicago  
Robert Petersen, Wheaton  
David Ford Rendleman, M.D., Carbondale  
Andrea R. Rozran, Chicago  
Mildred Louise Sammons, East St. Louis  
Jean A. Smith, Manteno  
John M. Stagl, Glenview  
Roger C. Stanley, Streamwood  
John F. Wayland, LaSalle  
Joyce C. Lashof, M.D., Chicago, *ex-officio*  
LeRoy Levitt, M.D., Chicago, *ex-officio*  
James L. Trainor, Springfield, *ex-officio*

### **Tuberculosis Advisory Committee**

Ben Kiningham, Springfield  
Eric Peterson, M.D., Coal Valley  
Mrs. Esther Smith, Chicago  
Virgil Smith, Metropolis  
H. H. Rohrer, M.D., Peoria



Whitney Addington, M.D., Chicago  
Richard C. Bodie, M.D., Aurora  
John C. Rogers, Glen Ellyn  
John Weisnar, Cairo

#### **Prevention of Accidental Poisoning in Children Advisory Committee**

Byron J. Francis, M.D., M.P.H., Springfield  
J. Keller Mack, M.D., Springfield  
W. L. Crawford, M.D., Rockford  
Paul Pierce, M.D., Alton  
Walter M. Whitaker, M.D., Quincy  
Joseph R. Christian, M.D., Chicago  
John B. Stull, M.D., Olney

#### **Illinois Health Facilities Authority**

George N. Hasapes, Skokie, *Executive Director*  
Stanford Glass, Winnetka, *Chairman*  
Roger D. Herrin, M.D., Harrisburg, *Vice-Chairman*  
Charles E. Hayes, Arlington Heights  
Louis G. Alexander, Chicago  
Martin Van Brown, Carbondale

Jorge Prieto, M.D., Evanston  
Irene Mills, Decatur

#### **Recreational Area Advisory Council**

William G. Crumrin, Martinsville  
Alvin Henninger, Garden Prairie  
Robert Stroyeck, Mt. Zion  
Edward Donahue, Springfield  
Frank Goetschel, New Lenox  
Kenneth Condit, Washburn  
Wm. Donels, Springfield

#### **Plumbing Code Advisory Council**

Edward F. Brabec, Chicago  
June B. Dezelan, Indianhead Park  
Kenneth E. Jackson, Rodhouse  
Richard Kelly, Granite City  
William D. Bland, Champaign  
Lester E. Koetz, Zion  
James Eischens, Moline  
Jerome O'Leary, Taylor Ridge

## **NON-STATUTORY BOARDS**

(Allied with Public Health Operations)

#### **Committee for Revision of the Rules and Regulations for the Control of Communicable Diseases**

Byron J. Francis, M.D., Springfield, *Chairman*  
John B. Hall, M.D., Chicago  
Helen Bruening, R.N., Springfield  
Richard A. Morrissey, Chicago  
Olga Brolnitsky, M.D., Chicago  
Hugh Rohrer, M.D., Peoria  
Stuart Levin, M.D., Chicago  
Daniel J. Pachman, M.D., Chicago, *ex-officio*  
Colette M. Rasmussen, M.D., Chicago

#### **Advisory Committee for Heritable Metabolic Diseases**

Julian Bierman, M.D., Chicago  
Herbert J. Grossman, M.D., Chicago  
John B. Hall, M.D., M.P.H., Chicago  
Edward F. Lis, M.D., Springfield  
Richard A. Morrissey, M.P.H., Chicago  
Margaret E. O'Flynn, M.D., Chicago  
Daniel J. Pachman, M.D., Chicago  
Ira M. Rosenthal, M.D., Chicago  
Parvin Justice, Ph.D., Chicago  
A. R. Sharp, M.D., St. Louis  
Paul Wong, M.D., Chicago  
Roslyn Duffy, R.N., Chicago

#### **Advisory Committee on Pediatric Lead Poisoning**

Fred Z. White, M.D., Chillicothe, *Chairman*  
A. J. Kiessel, M.D., Decatur, *Vice-Chairman*  
Ira M. Rosenthal, M.D., Chicago  
Guy A. Pandola, M.D., Joliet  
Eleanor Berman, Ph.D., Chicago  
Henrietta K. Sachs, M.D., Glencoe  
Ronald B. Mack, M.D., Berwyn  
Rowine Hayes-Brown, M.D., Chicago  
Richard A. Morrissey, Chicago  
Byron J. Francis, M.D., Springfield  
Joyce C. Lashof, M.D., *Ex-Officio*, Springfield

#### **Advisory Committee on Prevention of Accidental Poisoning in Children**

Byron J. Francis, M.D., Springfield, *Chairman*  
Joseph R. Christian, M.D., Chicago  
W. L. Crawford, M.D., Rockford  
J. Keller Mack, M.D., Springfield  
Paul Pierce, M.D., Alton  
John B. Stull, M.D., Olney  
Walter M. Whitaker, M.D., Quincy

#### **Youth Camp Advisory Council**

Marvin Erdal, Lake Villa  
Margaret Keeley, Chicago  
Byron Smalley, Oak Brook  
Robert Brower, Evanston  
William B. Detrich, Hudson

#### **Private Sewage Disposal Code Advisory Committee**

Robert Humphrey, North Aurora  
Gordon Ytell, Springfield  
Larry Sidener, Rochester  
Ben Boyd, Normal  
Orville Meyer, Wheaton  
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#### **Medical Advisory Board**

Wesley Betsill, M.D., Springfield  
Robert Bettasso, M.D., Ottawa  
Amos J. Brown, M.D., Chicago  
Joel Kaplan, M.D., Chicago  
James Kurtz, M.D., LaGrange  
Frank Norbury, M.D., Jacksonville  
Paul Schmidt, M.D., Galva  
Ronald Shlensky, M.D., Chicago  
Charles Whitfield, M.D., Springfield

#### **Hypertension Advisory Committee**

Eli L. Borkon, M.D., Carbondale, *Chairman*  
Richard Bilinsky, M.D., Springfield  
Richard Christansen, M.D., Rockford  
Gene Mann, B.S., M.P.H., Quincy  
Elizabeth Lynch, Springfield  
Ray Restivo, Chicago  
Robert St. John, Chicago  
David M. Berkson, M.D., Chicago  
James Schoenberger, M.D., Chicago  
Jeremiah Stamler, M.D., Chicago  
Ella M. Lacey, Carbondale

#### **Hemophilia Program Advisory Committee**

Edward F. Lis, M.D., Springfield, *Chairman*  
John Bouhasin, M.D., St. Louis  
David Green, M.D., Chicago  
George R. Honig, M.D., Chicago  
John Ippolito, Chicago  
Andre' D. Lascari, M.D., Springfield

Robert L. Pokorney, M.D., Lincoln  
Melvin Post, M.D., Chicago  
William Rushakoff, Chicago  
Bernard Stodsky, M.D., Chicago  
Margaret Telfer, M.D., Chicago

#### **Advisory Committee for the Child Hearing Test Act**

James R. Nelson, Springfield, *Exec. Sec.*  
Charles Pfothenauer, Springfield  
Lloyd Mosley, Springfield  
John B. Hall, M.D., Chicago  
Kenneth Mangan, Ed.D., Jacksonville  
Ralph Nauntun, M.D., Chicago  
William Plotkin, Ph.D., Chicago  
Paul Rittmanic, Ph.D., Dixon  
Robert K. Simpson, Ph.D., Champaign  
Ann Russell, Chicago  
George Skertich, South Holland  
Bill K. Tilley, Ph.D., Springfield

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### **POISON CONTROL CENTERS IN ILLINOIS**

For further information contact:  
Robert S. Nash, Chief of Clinical Services  
Division of Emergency Medical Services & Highway Safety  
Illinois Department of Public Health  
535 W. Jefferson  
Springfield, 62761  
Phone: (217) 782-5278

#### **ALTON**

Alton Memorial Hospital  
Memorial Drive  
(618) 462-8851

#### **AURORA**

Copley Memorial Hospital  
Lincoln & Weston Avenues  
(312) 897-6021, Ext. 725; 896-3911 Direct line

#### **BELLEVILLE**

Memorial Hospital  
4501 North Park Drive  
(618) 233-7750, Ext. 250

#### **BELVIDERE**

Highland Hospital  
1625 S. State Street  
(815) 547-5441, Ext. 367

#### **BERWYN**

MacNeal Memorial Hospital  
3249 S. Oak Park Avenue  
(312) 797-3159

#### **BLOOMINGTON**

Mennonite Hospital  
807 North Main Street  
(309) 828-5241, Ext. 395  
St. Joseph's Hospital  
2200 E. Washington  
(309) 662-3311, Ext. 356

#### **CAIRO**

Padco Community Hospital  
2020 Cedar Street  
(618) 734-2400, Ext. 42

#### **CANTON**

Graham Hospital Association  
210 W. Walnut Street  
(309) 647-5240, Ext. 240

#### **CARBONDALE**

Doctors Memorial Hospital  
404 West Main Street  
(618) 549-0721, Ext. 341

#### **CARTHAGE**

Memorial Hospital  
End of South Adams Street  
(217) 357-3131, Ext. 84 or 85

#### **CENTRALIA**

St. Mary's Hospital  
400 North Pleasant Avenue  
(618) 532-6731, Ext. 716

#### **CHAMPAIGN**

Burnham City Hospital  
407 South 4th  
(217) 337-2533

#### **CHANUTE AIR FORCE BASE**

United States Air Force Hospital  
(217) 495-3133  
Limited for treatment of military personnel  
and families, except for indicated civilian  
emergencies

#### **CHESTER**

Memorial Hospital  
1900 State Street  
(618) 826-4581



## CHICAGO

MASTER CHICAGO CENTER for information, treatment and reference on poisoning:

RUSH-PRESBYTERIAN-ST. LUKES MEDICAL CENTER  
1753 West Congress Parkway  
(312) 942-5969

Children's Memorial Hospital  
2300 Children's Plaza  
(312) 649-4161

Cook County Children's Hospital  
700 South Wood Street  
(312) 633-6542, 633-6543, or 633-6544

Mercy Hospital and Medical Center  
Stevenson Expressway & Martin Luther King Dr.  
(312) 567-2017

Michael Reese Medical Center  
29th and Ellis Avenue  
(312) 791-2810

Mt. Sinai Hospital  
California at 15th Street  
(312) 542-2030

Resurrection Hospital  
7435 West Talcott Avenue  
(312) 774-8000, Ext. 401

St. Mary of Nazareth Hospital Center  
2233 W. Division Street  
(312) 770-2419

South Chicago Community Hospital  
2320 East 93rd Street  
(312) 978-2000

University of Illinois Hospitals  
840 South Wood Street  
(312) 996-6885 or 996-6886

Wyler Children's Hospital  
950 East 59th Street  
(312) 947-6231

## DANVILLE

Lake View Medical Center  
812 North Logan Avenue  
(217) 443-5221

St. Elizabeth Hospital  
600 Sager Avenue  
(217) 442-6300, Ext. 647, 674 or 736

## DECATUR

Decatur Memorial Hospital  
2300 North Edward Street  
(217) 877-8121, Ext. 676

St. Mary's Hospital  
1800 East Lakeshore Drive  
(217) 429-2966, Ext. 731, 732, 733 or 742

## DE KALB

Kishwaukee Community Hospital  
Route 23 and Bethany Rd., P.O. Box 707  
(815) 756-1521, ext. 491

## DES PLAINES

Holy Family Hospital  
100 North River Road  
(312) 297-1800, Ext. 1000

## EAST ST. LOUIS

Christian Welfare Hospital  
1509 Martin Luther King Drive  
(618) 874-7076, Ext. 216 or 232

St. Mary's Hospital  
129 North 8th Street  
(618) 274-1900, Ext. 204 or 268

## EFFINGHAM

St. Anthony Memorial Hospital  
503 North Maple Street  
(217) 342-2121, Ext. 211 or 212

## ELGIN

St. Joseph Hospital  
77 Airlite Street  
(312) 695-3200 Ext. 348

Sherman Hospital  
934 Center Street  
(312) 742-9800, Ext. 681

## ELMHURST

Memorial Hospital of DuPage County  
209 Avon Road  
(312) 833-1400, Ext. 550

## EVANSTON

Evanston Hospital  
2650 Ridge Avenue  
(312) 492-6460

St. Francis Hospital  
355 Ridge Avenue  
(312) 492-2440

## EVERGREEN PARK

Little Company of Mary Hospital  
2800 West 95th Street  
(312) 445 6000, Ext. 221

## FAIRBURY

Fairbury Hospital  
519 South Fifth Street  
(815) 692-2346, Ext. 248

## FREEPORT

Freeport Memorial Hospital  
420 South Harlem Avenue  
(815) 235-4131, Ext. 228

## GALESBURG

Galesburg Cottage Hospital  
695 North Kellogg  
(309) 343-8131, Ext. 356, 386 or 336

St. Mary's Hospital  
3333 North Seminary  
(309) 343-3161, Ext. 255 or 256

## GRANITE CITY

St. Elizabeth Hospital  
2100 Madison Avenue  
(618) 876-2020, Ext. 421

## HARVEY

Ingalls Memorial Hospital  
One Ingalls Drive  
(312) 333-2300, Ext. 5295

## HIGHLAND

St. Joseph's Hospital  
1515 Main Street  
(618) 654-2171, Ext. 297 or 298

## HIGHLAND PARK

Highland Park Hospital  
718 Glenview Avenue  
(312) 432-8000

## HINSDALE

Hinsdale San. & Hospital  
120 North Oak Street  
(312) 887-2600

## HOOPESTON

Hoopeston Community Memorial Hospital & Nursing Home  
701 East Orange Street  
(217) 283-5531

**JACKSONVILLE**

Passavant Memorial Area Hospital  
1600 West Walnut  
(217) 245-9541

**JOLIET**

St. Joseph Hospital  
333 North Madison Street  
(815) 725-7133, Ext. 571, 572, 573 or 574

Silver Cross Hospital  
1200 Maple Road  
(815) 729-7563 or 729-7565

**KANKAKEE**

Riverside Hospital  
350 North Wall Street  
(815) 933-1671, Ext. 606

St. Mary's Hospital  
500 West Court  
(815) 937-2100

**KEWANEE**

Kewanee Public Hospital  
719 Elliott Street  
(309) 853-3361, Ext. 219

**LAKE FOREST**

Lake Forest Hospital  
660 Westmoreland  
(312) 234-5600, Ext. 683, 684 or 685

**LASALLE**

St. Mary Hospital  
1015 O'Connor Avenue  
(815) 223-0607, Ext. 14

**LINCOLN**

Abraham Lincoln Memorial Hospital  
315 Eighth Street  
(217) 732-2161, Ext. 346

**MACOMB**

McDonough District Hospital  
525 East Grant Street  
(309) 833-4101, Ext. 433

**MATTOON**

Memorial Hospital  
2101 Champaign Avenue  
(217) 234-8881, Ext. 29

**MAYWOOD**

Loyola University Foster G. McGaw Hospital  
2160 South Ist Avenue  
(312) 531-3000

**McHENRY**

McHenry Hospital  
3516 West Waukegan Road  
(815) 385-2200, Ext. 602

**MELROSE PARK**

Westlake Community Hospital  
1225 Superior Street  
(312) 681-3000, Ext. 226 or 239

**MENDOTA**

Mendota Community Hospital  
Memorial Drive  
(815) 539-7461, Ext. 225

**MOLINE**

Moline Public Hospital  
635-10th Avenue  
(309) 762-3651, Ext. 233

**MONMOUTH**

Community Memorial Hospital  
1000 West Harlem Avenue  
(309) 734-3141, Ext. 224

**MOUNT CARMEL**

Wabash General Hospital  
1418 College Drive  
(618) 263-3112, Ext. 211

**MOUNT VERNON**

Good Samaritan Hospital  
605 North Twelfth Street  
(618) 242-4600, Ext. 521

**NAPERVILLE**

Edward Hospital  
South Washington Street  
(312) 355-0450, Ext. 326

**NORMAL**

Brokaw Hospital  
Virginia at Franklin Avenue  
(309) 829-7685, Ext. 274

**OAK LAWN**

Christ Community Hospital  
4440 West 95th Street  
(312) 425-8000, Ext. 382

**OAK PARK**

West Suburban Hospital  
518 N. Austin Boulevard  
(312) 383-6200

**OLNEY**

Richland Memorial Hospital  
800 East Locust Street  
(618) 395-2131, Ext. 226 or 228

**OTTAWA**

Community Hospital of Ottawa  
1100 E. Norris Drive  
(815) 433-3100, Ext. 227

**PARK RIDGE**

Lutheran General Hospital  
1775 Dempster Street  
(312) 696-5151

**PEKIN**

Pekin Memorial Hospital  
14th & Court Streets  
(309) 347-1151, Ext. 430

**PEORIA**

Methodist Hospital of Central Illinois  
221 N.E. Glen Oak  
(309) 672-5500

Proctor Community Hospital  
5409 N. Knoxville Avenue  
(309) 691-4702, Ext. 791

St. Francis Hospital Medical Center  
530 N.E. Glen Oak Avenue  
(309) 672-2109, 672-2110 or 672-2111

**PERU**

Peoples Hospital  
925 West Street  
(815) 223-3300, Ext. 253

**PITTSFIELD**

Illini Community Hospital  
640 West Washington Street  
(217) 285-2113, Ext. 238



**PRINCETON**

Perry Memorial Hospital  
530 Park Avenue East  
(815) 875-2811, Ext. 311

**QUINCY**

Blessing Hospital  
1005 Broadway  
(217) 223-5811, Ext. 255  
St. Mary Hospital  
1415 Vermont Street  
(217) 223-1200, Ext. 260

**ROCKFORD**

Rockford Memorial Hospital  
2400 N. Rockton Avenue  
(815) 968-6861, Ext. 441  
St. Anthony Hospital  
5666 E. State Street  
(815) 226-2041  
Swedish-American Hospital  
1316 Charles Street  
(815) 968-6898, Ext. 534

**ROCK ISLAND**

Rock Island Franciscan Hospital  
2701 17th Street  
(309) 793-1000, Ext. 2106

**ST. CHARLES**

Delnor Hospital  
975 N. Fifth Avenue  
(312) 584-3300, Ext. 229

**SCOTT AIR FORCE BASE**

USAF Medical Center  
(618) 256-7595

**SPRINGFIELD**

Memorial Medical Center  
First and Miller Streets  
(217) 528-2041, Ext. 460  
St. John's Hospital  
800 East Carpenter  
(217) 544-6464, Ext. 210

**SPRING VALLEY**

St. Margaret's Hospital  
600 E. First Street  
(815) 663-2611, Ext. 464 or 466

**STREATOR**

St. Mary's Hospital  
111 East Spring Street  
(815) 673-2311, Ext. 221

**URBANA**

Carle Foundation Hospital  
602 W. University Avenue  
(217) 337-3311  
Mercy Hospital  
1400 West Park Avenue  
(217) 337-2131

**WAUKEGAN**

St. Therese Hospital  
2615 West Washington Street  
(312) 688-6470  
Victory Memorial Hospital  
1324 N. Sheridan Road  
(312) 688-6181

**WINFIELD**

Central DuPage Hospital  
0 North, 025 Winfield Road  
(312) 653-6900, Ext. 556

**WOODSTOCK**

Memorial Hospital for McHenry County  
527 W. South Street  
(815) 338-2500, Ext. 215 or 232

**ZION**

Zion-Benton Hospital  
Shiloh Boulevard  
(312) 872-4561, Ext. 239 or 240

**APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS****Illinois Department of Public Health****Division of Disease Control**

Michael Reese Hospital and Medical Center  
29th Street and Ellis Ave., Chicago 60616  
Victoria Lim, M.D.

Rush-Presbyterian-St. Luke's Medical Center  
1753 West Congress Parkway, Chicago 60612  
Jimmie Roberts, M.D.

Washington University Renal Unit  
Chromalloy American Kidney Center  
(Barnes Hospital)  
4949 Barnes Hospital Plaza, St. Louis, Mo. 63110  
Herschel Harter, M.D.

The Jewish Hospital of St. Louis  
216 South Kingshighway, St. Louis, Mo. 63110  
Herbert Lubowitz, M.D.

Springfield Medical Center  
First and Miller Sts., Springfield 62701  
Richard Bilinsky, M.D.

Evanston Hospital  
2650 Ridge Ave., Evanston 60201  
Walid Ghantous, M.D.

University Hospitals (Wisconsin)  
Department of Medicine  
1300 University Ave., Madison, Wis. 53706  
Arvin B. Weinstein, M.D.

University of Illinois Research and Educational  
Hospitals  
840 South Wood St., Chicago 60612  
Christopher Westenfelder, M.D.

Mayo Clinic  
Internal Medicine & Nephrology, Rochester, Minn. 55901  
William J. Johnson, M.D.

University of Chicago Hospitals & Clinics  
950 East 59th St., Chicago 60649  
Adrian Katz, M.D.

Mt. Sinai Hospital Medical Center  
Fifteenth and California Aves., Chicago 60608  
Earl C. Smith, M.D.

Northwestern Medical Center  
Passavant Pavillion  
303 East Superior St., Chicago 60611  
Frank Krumlovsky, M.D.

West Suburban Hospital  
518 North Austin Blvd., Oak Park 60302  
Robert C. Muehrcke, M.D.

Rockford Memorial Hospital  
2300 North Rockton Ave, Rockford 61101  
Ewald T. Sorensen, M.D.

Cook County Hospital  
1825 West Harrison St., Chicago 60612  
George Dunea, M.D.

St. Francis Hospital  
523 N.E. Glen Oak, Peoria 61603  
Robert Pfederer, M.D.

The Children's Memorial Hospital  
2300 Children's Plaza, Chicago 60614  
Peter R. Lewy, M.D.

Lake View Memorial Hospital  
812 North Logan Ave., Danville 61832  
Raja M. Sadiq, M.D.

Mercy Hospital  
1400 West Park Ave., Urbana 61801  
R. E. Tirona, M.D.

St. Joseph Hospital  
2900 North Lake Shore Dr., Chicago 60657  
Gordon Lang, M.D.

Galesburg Cottage Hospital  
674 North Seminary St., Galesburg 61401  
Agha Babanoury, M.D.

Roosevelt Memorial Hospital  
426 West Wisconsin St., Chicago 60614  
Franklin D. Schwartz, M.D.

Ingalls Memorial Hospital  
One Ingalls Drive, Harvey  
Alexander B. White, M.D.

Doctors Memorial Hospital  
404 West Main St., Carbondale 62901  
Max Wekel, M.D.

Blessing Hospital  
1005 Broadway, Quincy 62301  
Hugh Espey, M.D.

Jefferson County Memorial Hospital  
909 Shawnee St., Mt. Vernon 62864  
Robert Parks, M.D.

Victory Memorial Hospital  
1324 North Sheridan Rd., Waukegan 60085  
John Freeland, M.D.

Central DuPage Hospital  
0 North 025 Winfield Rd., Winfield 60190  
Paul Balter, M.D.

Loyola University (Foster G. McGaw) Hospital  
2160 South First Ave., Maywood 60153

St. Margaret Hospital  
25 Douglas St., Hammond, Ind. 46320  
James H. Greenwald, M.D.

Edgewater Hospital  
5700 N. Ashland, Chicago 60660  
James Yeung, M.D.

St. Elizabeth's Hospital  
211 S. Third St., Belleville 62221  
Joseph Santiago, M.D.

Silver Cross Hospital  
600 Walnut St., Joliet 60432  
Robert S. Markelz, M.D.

Christ Hospital  
4440 W. 95th St., Oak Lawn 60453  
Joseph H. Oyama, M.D.

Memorial Hospital of DuPage  
209 Avon Road, Elmhurst 60126  
John Simonaitis, M.D.

Good Samaritan Hospital  
Vincennes, Indiana 47591  
John S. Murray, M.D.

St. Louis Children's Hospital  
500 S. Kingshighway, St. Louis, Mo. 63110  
Barbara Cole, M.D.

*Dialysis for Veterans with kidney disease is available at:*  
Veterans Administration Hospital, Hines 60141  
Veterans Administration Research Hospital, Chicago 60153  
Peter Ivonovich, M.D.

Chicago Osteopathic Hospital  
5200 South Ellis Ave., Chicago 60615  
Donald L. Hollandsworth, D.O.

St. Louis University Hospital  
1320 South Grand Boulevard, St. Louis 63104  
Robert Cuddihee, M.D.

University of Iowa Hospitals and Clinics  
Iowa City, Iowa 52242  
Carl J. Richards, M.D.

St. Luke's Hospital  
1227 East Rusholme, Davenport, Iowa 52803  
E. A. Motto, M.D.

Sherman Hospital  
934 Center Street, Elgin 60120  
Nasir J. Ahmad, M.D.

St. Mary's Hospital  
500 West Court St., Kankakee 60901  
Tapendu Kumar Basu, M.D.

Alexian Brothers Medical Center  
800 West Biesterfield Road, Elk Grove Village 60007  
Paul A. Balter, M.D.

Oommen A. Koshy, M.D.  
(Part West Sub. Kidney Ctr. Group)

#### Satellites or Limited Care Facilities

*West Suburban Kidney Center*  
Robert C. Muehrcke, M.D.  
733 Madison St., Oak Park

*Lombard Unit*  
First Church of Lombard, Lombard 60148

*Chicagoland Dialysis Center*  
Cathedral Shelter  
Ashland and Adams, Chicago 60607  
Robert C. Muehrcke, M.D.

*S. Side Dialysis Unit*  
7721 S. Western Ave., Chicago 60620

*University of Illinois Hospitals*  
Dialysis Centers, Limited  
4800 N. Kilpatrick, Chicago 60610  
740 N. Rush St., Chicago 60610  
Franklin D. Schwartz, M.D.

*Springfield Medical Center*  
Richard Bilinsky, M.D.

*Renal Facility*  
Springfield 62702

*Alton Memorial Hospital*  
Alton 62002

*Decatur Memorial Hospital*  
Decatur 62521

*Effingham Limited Care Facility*  
206 N. 4th St., Effingham 62401

*Norris Hospital*  
Jacksonville 62650



*Evanston Hospital Dialysis Center*

Niles-Day-Springman Satellite  
Lawrencewood Shopping Center  
Waukegan Rd., Niles 60648  
Walid Ghantous, M.D.

*North Central Dialysis Centers*

55 E. Washington Blvd., Chicago 60603  
Alan Kanter, M.D.

North Suburban Dialysis Center  
1601 Sherman Ave., Evanston 60201  
Walid Ghantous, M.D.

Northwest Suburban Nephrology Center  
600 North Court Street, Palatine 60067  
Walid Ghantous, M.D.  
Gordon Lang, M.D.

*Victory Memorial Hosp.*

Lake County Dialysis Association  
711 Glen Flora Ave., Waukegan 60085  
John P. Freeland, M.D.

Southern Illinois Kidney Center  
Westown Mall, Carbondale 62901  
Max L. Webel, M.D.

*For further information contact:*

Mrs. Ruth S. Shriner, ACSW—Coordinator Direct Services  
Programs, Illinois Department of Public Health  
Room 150, 535 West Jefferson Street, Springfield 62706  
Phone (217) 782-3303

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**ARTIFICIAL KIDNEYS FOR ACUTE POISONING CASES**

*(Alphabetically by Community)*

Northwest Community Hospital 800 W. Central Rd. Arlington Heights	Phone: 259-1000 Person in Charge: Gordon R. Lang, M.D. Location in Hosp: Intensive Care
Copley Memorial Hospital Lincoln & Weston Avenues Aurora	Phone: 897-6021 Person in Charge: M. J. Carbon, M.D. Location in Hosp: Intermediate Care
St. Elizabeth's Hospital 211 S. 3rd Street Belleville	Phone: 234-2120, Ext. 285 Person in Charge: Joseph Santiago, M.D. Sister Jamesine Lamb, R.N. Location in Hosp: Hemodialysis Unit
St. Francis Hospital 12935 S. Gregory Blue Island	Phone: 597-2000 Person in Charge: Dr. Otero Location in Hosp: Intensive Care Unit
Doctors Memorial Hospital 404 West Main Carbondale	Phone: 549-0721 Person in Charge: M. Wekel, M.D. Location in Hosp: Renal Dialysis
Burnham City Hospital 407 S. Fourth Street Champaign	Phone: 337-2500 Person in Charge: Reynaldo Tirona, M.D. Location in Hosp: Trauma Center—ICU Unit
Chicago Osteopathic Medical Center 5200 S. Ellis Avenue Chicago	Phone: 363-6800 Person in Charge: Donald Hollandsworth, D.O. Location in Hosp: Renal Medicine
Children's Memorial Hospital 2300 Children's Plaza Chicago	Phone: 649-4000 Person in Charge: Peter Lewy, M.D. Location in Hosp: Nephrology
Columbus Hospital 2520 N. Lakeview Avenue Chicago	Phone: 883-6427 Person in Charge: Gordon Lang, M.D. Location in Hosp: Intensive Care Unit
Cook County Hospital 1825 West Harrison Chicago	Phone: 633-6000 Person in Charge: George Dunca, M.D. Location in Hosp: Nephrology-Internal Medicine
Edgewater Hospital 5700 N. Ashland Avenue Chicago	Phone: 878-6000 Person in Charge: Gabriel Schwartz, M.D. Location in Hosp: Nephrology
Mercy Hospital & Medical Center Stevenson Expressway at King Drive Chicago	Phone: 567-2000 Person in Charge: Carlos Otero, M.D. Location in Hosp: Intensive Care Unit
Michael Reese Hosp. & Medical Center 2900 S. Ellis Chicago	Phone: 791-2242 Person in Charge: B. Levin, M.D. Location in Hosp: Dialysis Section Dept.

Mt. Sinai Hospital Medical Center of Chicago 15th & California Avenue Chicago	Phone: 542-2000 Person in Charge: Earl Smith, M.D. Location in Hosp: Hemodialysis Unit
Northwest Hospital Inc. 5645 W. Addison St. Chicago	Phone: 282-7000 Person in Charge: Jayme Neuman, M.D. Location in Hosp: Intensive Care
Northwestern Memorial Hospital Superior & Fairbanks Court Chicago	Phone: 649-3327 Person in Charge: Francesco delGreco, M.D. Location in Hosp: Dialysis Dept.
Rush-Presbyterian-St. Luke's 1753 West Congress Parkway Chicago	Phone: 942-5000 Person in Charge: Jimmie Roberts, M.D. Location in Hosp: Dialysis Unit, Nephrology
Ravenswood Hospital Medical Center 4550 N. Winchester Chicago	Phone: 878-4300 Person in Charge: Gordon Lang, M.D. Location in Hosp: Medicine
Roosevelt Memorial Hospital 426 W. Wisconsin Chicago	Phone: 751-4000 Person in Charge: J. Feldstein, M.D. Location in Hosp: Dialysis
St. Joseph Hospital 2900 N. Lake Shore Drive Chicago	Phone: 975-3027 Person in Charge: Gordon Lang, M.D. Location in Hosp: Renal Dialysis
University of Chicago Hospital & Clinics 950 E. 59th Chicago	Phone: 947-1000 Person in Charge: Adrian Katz, M.D. Location in Hosp: Kidney Dialysis Lab.
University of Illinois Hospital 840 S. Wood St. Chicago	Phone: 996-7000 Person in Charge: Neil A. Kurtzman, M.D. Location in Hosp: Medicine
Lake View Memorial Hospital 812 N. Logan Avenue Danville	Phone: 443-5000 Person in Charge: Sharon Tuggle, R.N. Location in Hosp: Intensive Care & Hemodialysis Unit
St. Joseph Hospital 77 Airlite Elgin	Phone: 695-3200 Person in Charge: Gerald Pearson Location in Hosp: Emergency Dept.
Sherman Hospital 934 Center Street Elgin	Phone: 742-9800 Person in Charge: Nasir Ahmad, M.D. Location in Hosp: Nursing Dept.
Alexian Brothers Medical Center 800 W. Biesterfield Road Elk Grove Village	Phone: 437-5500 Person in Charge: Paul Balter, M.D. Location in Hosp: Renal Dialysis Unit
Memorial Hospital of DuPage Co. 209 Avon Road Elmhurst	Phone: 833-1400 Person in Charge: Mrs. O. Pupp, Head Nurse Location in Hosp: Renal Dialysis
Evanston Hospital 2650 Ridge Avenue Evanston	Phone: 492-2000 Person in Charge: Marshall Salkin, M.D. Location in Hosp: Hemodialysis
St. Francis Hospital of Evanston 355 Ridge Avenue Evanston	Phone: 492-4000 Person in Charge: John O'Malley Location in Hosp: Intensive Care Unit
Freeport Memorial Hospital 420 South Harlem Avenue Freeport	Phone: 235-4131 Person in Charge: C. W. Metcalf, M.D. Location in Hosp: Inhalation Therapy
Galesburg Cottage Hospital 695 N. Kellogg Galesburg	Phone: 343-8131 Person in Charge: Agha Babanoury, M.D. Location in Hosp: Hemodialysis Unit



Ingalls Memorial Hospital One Ingalls Drive Harvey	Phone: 333-2300 Person in Charge: Location in Hosp:	Barbara Nelson, R.N. Renal Dialysis
Silver Cross Hospital 1200 Maple Road Joliet	Phone: 729-7111 Person in Charge: Location in Hosp:	R. A. Markelz, M.D. Renal Dialysis
St. Mary's Hospital 500 W. Court Street Kankakee	Phone: 937-2490 Person in Charge: Location in Hosp:	T. Basu, M.D. Dialysis Unit
Foster G. McGaw Hosp. of Loyola University 2160 South 1st Avenue Maywood	Phone: 531-3000 Person in Charge: Location in Hosp:	Austin Currens Renal Dialysis
Jefferson Memorial Hospital 909 Shawnee Mt. Vernon	Phone: 242-3400 Person in Charge: Location in Hosp:	Barbara Cailteux, R.N. Kidney Dialysis Unit
West Suburban Hospital 518 N. Austin Blvd. Oak Park	Phone: 383-6200 Person in Charge: Location in Hosp:	Zoe Morrissey, R.N. Kidney Dialysis Center
Christ Hospital 4440 West 95th St. Oak Lawn	Phone: 425-8000 Person in Charge: Location in Hosp:	Joseph Oyama, M.D. Hemodialysis
Methodist Hospital of Central Illinois 221 N.E. Glen Oak Ave. Peoria, Illinois 61603	Phone: 672-5522 Person in Charge: Location in Hosp:	Barbara Losen, R.N. J. Meyers, M.D. Medicine
St. Francis Hospital Medical Center 530 N.E. Glen Oak Peoria	Phone: 672-2000 Person in Charge: Location in Hosp:	R. A. Pflederer, M.D. Hemodialysis
Lutheran General Hospital 1775 Dempster Street Park Ridge	Phone: 696-2210 Person in Charge: Location in Hosp:	Margaret Bischel, M.D. Medicine
Blessing Hospital 1005 Broadway Quincy	Phone: 223-5811 Person in Charge: Location in Hosp:	Mrs. Marian Almasey, R.N. Renal Dialysis
Rockford Memorial Hospital 2400 N. Rockton Ave. Rockford	Phone: 968-6861 Person in Charge: Location in Hosp:	E. T. Sorensen, M.D. Renal Dialysis
Memorial Medical Center 1st & Miller Springfield	Phone: 528-2041 Person in Charge: Location in Hosp:	Dr. Richard Bilinsky Renal Unit
Mercy Hospital 1400 West Park Urbana	Phone: 337-2284 Person in Charge: Location in Hosp:	R. F. Tirona, M.D. and Dr. Humphreys Mr. Michael Lueth Hemodialysis Unit
Victory Memorial Hospital 1324 North Sheridan Road Waukegan	Phone: 688-3000 Person in Charge: Location in Hosp:	John P. Freeland, M.D. Dialysis Unit
Central DuPage Hospital 0 N 025 Winfield Road Winfield	Phone: 653-6900 Person in Charge: Location in Hosp:	P. Balter, M.D. Kidney Dialysis

*In addition to the hospitals in Illinois, we have also received information that the following hospital has an artificial kidney. This out of state hospital may be more accessible in some emergencies than those in Illinois:*

Barnes Hospital 4949 Barnes Hospital Plaza St. Louis, Missouri	Phone: 454-2000 Person in Charge: Location in Hosp:	Dr. Edwardo Slatapolsky 2nd Floor
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## DEPARTMENT OF REGISTRATION AND EDUCATION

628 East Adams Street, Springfield  
55 East Jackson Boulevard, Chicago

Ronald E. Stackler, *Director*  
Billie J. Paige, *Assistant Director*  
Jerry D. Sternstein, *Deputy Director-Licensing*  
Jacob M. Shapiro, *Chief Counsel*  
Algis Augustine, *Chief Regulatory Officer*

The department is primarily concerned with the registration, licensing and enforcement of 34 laws governing the different professions, trades and occupations, including the Medical Practice Act. The enforcement of the Medical Practice Act is the responsibility of the Medical Coordinator for the Medical Disciplinary Board, John M. Fultz, Jr., M.D.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

### Medical Examining Committee

Robert S. Mendelsohn, M.D., Evanston, *Chairman*  
David Greeley, M.D., Evanston  
Dale E. Richardson, D.O., Pontiac  
Paul Tullio, D.C., Glen Ellyn  
Basil Chronis, M.D., Palos Heights  
Mays C. Maxwell, M.D., East St. Louis  
Luis Yarzagaray, M.D., Highland Park

### Medical Disciplinary Board

Williard C. Scrivner, M.D., Belleville  
Levon Krikor Topouzian, M.D., Skokie  
Helen C. Bonbrest, M.D., Chicago  
James B. Williams, M.D., Chicago  
Raimundo Rodriguez, M.D., Murphysboro  
Sam Brinkley, D.C., East Alton  
George Caleel, D.O., Chicago, *Chairman*

### Medical Practice Act

#### LICENSING AND ENFORCEMENT PROCEDURES

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no person shall practice medicine, or any of its branches, or midwifery, or any system or method of treating human ailments without the use of drugs or medicines and without operative surgery, without a valid, existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who

has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

(a) the expiration of 6 months after the filing of such written application, or

(b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or

(c) the withdrawal of the application. (Added by Act approved July 26, 1971)

Any person licensed under this Act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dispensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. (Added by Act approved September 24, 1971)

*Minimum standards of professional education.* Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of



the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been the department.

The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing. (added by Act approved July 26, 1971).

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human ailments as offered by such college or school of medicine, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of three years course of instruction in an accredited college of liberal arts or its equivalent; that such applicant submit an application to an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and

licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1978, for an applicant who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years course of instruction in an accredited college of liberal arts or its equivalent; that such an applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been reputable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all license requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1978, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1978, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this State for candidates who have completed the requirements of this sub-section.

Until September 1, 1978, no hospital licensed by the State, or operated by the State or political subdivision thereof, or which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1978, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic

year of supervised clinical training at a medical school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. (Added by Act approved Sept. 7, 1974).

*2. Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school,

college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

*3. Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment. As amended by act approved Sept. 7, 1974, and March 4, 1975.

All examinations provided for by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that as will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of \$40.

#### CONTINUING EDUCATION

The Department, based on the written recommendation of the Examining Committee, shall promulgate mandatory requirements of continuing education for persons licensed pursuant to this Act. In establishing such recommendations, the Committee shall:

- (1) Develop practical and meaningful criteria for defining and describing continuing education requirements which meet, but are not limited to, the following specifications:



- (a) Readily available to all practicing physicians in Illinois without undue commitment of time away from practice and expense on the part of the practitioner.
  - (b) Compatible with existing requirements of licensing agencies in other states.
  - (c) Compatible with the requirements of medical specialty boards for recertification of specialty status.
  - (d) Compatible with the continuing education requirements developed by national medical specialty societies.
  - (e) Compatible with continuing education programs and requirements that are developed in federally mandated peer review programs and as a part of Professional Standards Review Organizations.
  - (f) Provides for differing requirements for licensees engaged in other than direct patient care (example: educators, researchers and those engaged in medical administration).
  - (g) Provides for compatible requirements for licensees in the federal uniformed services, those engaged in formal residency and fellowship training programs, and licensees operating under hospital permit licensure.
- (2) Conceive, develop and evaluate procedures, materials and systems to carry out the administrative requirements of this legislation which include, but are not limited to, the following:
- (a) Procedures for prompt and fair evaluation of reports of educational achievement submitted by licensees.
  - (b) Requirements and position descriptions for personnel engaged in reviewing and evaluating reports and continuing educational achievements submitted by licensees.
  - (c) A data recording system for gathering, analyzing, storing and retrieving information on individual licensee educational accomplishments.
  - (d) Provision for licensee to appeal adverse actions and temporary exemptions from requirements under unusual circumstances.
  - (e) Exemption from legal prosecution of all persons responsible for action taken under the program.
  - (f) Establishment of realistic budgeting and cost requirements for the personnel, and operational funds necessary to plan, develop and operate the program.
  - (g) Procedures for surveying and evaluating the effectiveness of the program.
  - (h) Orderly procedures for adequate notice to licensee of pending action that may result in non-renewal of license, including provisions for consultation and assistance in time for him to meet the requirements of this Act.
- (3) Develop adequate protection for information about licensee participation in continuing education as it pertains to all aspects of practice liability and the licensee's public image and his relationships with individual patients.
- (4) Develop an advisory panel for each category of licensee to advise and assist the department in development and application of continuing education criteria, administrative procedures and policy.

- (5) Develop procedures for assuring that the educational opportunities available to licensees for fulfilling the requirements of this act are of appropriate scope, variety, depth and of high quality.

The Department shall enforce these requirements; however, the Department shall be empowered to waive enforcement of these requirements in localities where it is demonstrated that the absence of opportunities for such education would interfere with the adequacy of medical services in that locality.

Added by Act eff. July 1, 1976.

#### REVOCATION AND SUSPENSION OF LICENSE OR CERTIFICATE

The Department may revoke, or suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or state hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

- "1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;
- 2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court, unless such person demonstrates to the Department that he has been sufficiently rehabilitated to warrant the public trust; (as amended by Act approved August 19, 1975);
- 3. Gross or repeated malpractice resulting in serious injury or death of a patient (as amended by Act approved August 19, 1975);
- 4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
- 5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;
- 6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance

- of professional duties;
7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
  8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;
  9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;
  10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
  11. Revocation or suspension of a medical license in a sister state;
  12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
  13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."
  14. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divided a fee: provided, the patient has full knowledge of the division, and provided that the division is made in proportion to the services performed and responsibility assumed by each.
  15. A finding by the Committee that the registrant after having his license placed on probationary status violated the terms of the probation.
  16. All advertising of medical business which is intended, or has a tendency, to deceive the public or impose upon credulous or ignorant persons and so be harmful or injurious to public morals or safety.
  17. All advertising of any medicine or of any means whereby the monthly menses of women can be regulated or reestablished if suppressed.
  18. Abandonment of a patient.
  19. The use of prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes.
  20. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.
  21. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department of Registration and Education.
  22. Immoral conduct in practice as a physician, or repeated acts of gross misconduct.
  23. Willfully making or filing false records or reports in his practice as a physician.
  24. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law.
  25. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee.
  26. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered.
  27. Professional incompetence as manifested by poor standards of care or mental incompetency as declared by a court of competent jurisdiction (as amended by Act approved August 19, 1976);
  28. Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill or safety.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, certificate or state hospital permit on any of the foregoing grounds, except the ground numbered 8 (fraudulent groups expected) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, certificate or state hospital permit was without the State of Illinois shall not be included within the 3 years.



The entry of an order or judgment by any circuit court establishing that any person holding a license, certificate or state hospital permit under this Act is a person in need of mental treatment operates as a suspension of that license, certificate or state hospital permit. That person may resume his practice only upon a finding by the Medical Disciplinary Board that he has been determined to be recovered from mental illness by the court and upon the Board's recommendation that he be permitted to resume his practice.

**Section 16.01.** Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

#### MEDICAL DISCIPLINARY BOARD

There has been created the Illinois State Medical Disciplinary Board, which consists of 7 members, appointed by the Governor by and with advice and consent of the Senate. All shall be residents of the State, not more than 4 of whom shall be members of the same political party. Five members shall be physicians licensed to practice medicine in all of its branches in Illinois. One member shall be an Illinois physician possessing the degree of doctor of osteopathy. One member shall be a person licensed in Illinois and possessing a chiropractor's degree.

a. Of the members of the Board first appointed, two shall be appointed for terms of 2 years; two shall be appointed for terms of 3 years, and three shall be appointed for terms of 4 years. Upon the expiration of the term of any member, his successor shall be appointed for a term of four years by the Governor by and with the advice and consent of the Senate. The Governor shall fill any vacancy for the remainder of the unexpired term by and with the advice and consent of the Senate. Upon recommendation of the Board, any member of the Board may be removed by the Governor for misfeasance, malfeasance, or willfull neglect of duty after notice and a public hearing unless such notice and hearing shall be expressly waived in writing. Each member shall serve on the Board until his successor is appointed and qualified. No member of the Board shall serve more than two consecu-

tive four year terms.

In making appointments the Governor shall attempt to insure that the various social and geographic regions of the State of Illinois are properly represented.

In making the designation of persons to act for the several professions represented on the Board, the Governor shall give due consideration to recommendations by members of the respective professions and by organizations therein.

- b. The Board shall annually elect one of its members as chairman, one as vice chairman and one as secretary. No officer shall be elected more than twice in succession to the same office. Each officer shall serve until his successor has been elected and qualified.
  - c. The secretary shall keep a record of the proceedings of the Board and shall be custodian of all books, documents and papers filed with the Board, including the minute book or journal of the Board. The secretary or other persons authorized by the Board may cause copies to be made of all minutes and other records and documents of the Board and may give certificates of the Board to the effect that such copies are true copies, and all persons dealing with the Board may rely upon such certificates.
  - d. Four members of the Board shall constitute a quorum. A vacancy in the membership of the Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the Board. Any action taken by the Board under this Act may be authorized by resolution at any regular or special meeting and each such resolution shall take effect immediately. The Board shall meet at least quarterly. The Board is empowered to adopt all rules and regulations necessary and incident to the powers granted to it under this Act.
  - e. Each member, and member-officer, of the Board shall receive a per-diem stipend as the Director of the Department of Registration and Education hereinafter referred to as the Director, shall determine. Each member shall be paid his necessary expenses while engaged in the performance of his duties.
  - f. The Director shall in conformity with the "Personnel Code," as now or hereafter amended, select a medical coordinator, who shall not be a member of the Board. The medical coordinator shall be a physician licensed to practice medicine in all of its branches, and the Director shall set his rate of compensation. The medical coordinator shall be the chief enforcement officer of the Medical Practice Act and shall serve at the will of the Board.
- The Director shall employ, in conformity with the Personnel Code, not less than one (1) full time investigator for every 5000 physicians licensed to practice medicine in the State. Each investigator shall be a college graduate with at least two years' investigative experience or one year advanced medical education. Upon the written request of the Board, the Director shall employ, in conformity with the Personnel Code, such other professional, technical, investigative, and clerical help, either as a full or part-time basis as the Board deems necessary for the proper performance of its duties. All employees

of the Board shall be directed by, and answerable to, the Board with respect to their duties and functions.

- g. Upon the specific request of the Board, signed by either the chairman, vice chairman, or medical coordinator of the Board, the Bureau of Drug Compliance, the Office of Professional Supervision of the Department of Registration and Education, the Illinois Law Enforcement Commission, the Illinois Bureau of Investigation, the Illinois Legislative Investigating Commission shall.

(1) Make available any and all information that they shall have in their possession regarding a particular case then under investigation by the Board.

- h. Members of the Board shall be immune from suit in any action based upon any disciplinary proceedings of other acts performed in good faith as members of the Board.

Added by Act eff. Nov. 21, 1975.

### ECFMG Requirements

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is not a substitute for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

### Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.

5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.

6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(*Medical Practice Act*. [Chp. 91, Sec. 16i, Paragraph 24, 1975 *Rev. Stat.*])

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspension of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.
3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

### Physician's Assistant Act

*Section 1.* The purpose and legislative intent of this Act is to encourage and promote the more effective utilization of the skills of physicians by enabling them to delegate certain health tasks to physician's assistants where such delegation is consistent with the health and welfare of the patient and is conducted at the direction of and under the responsible supervision of the physician.

*Section 2.* This Act shall be known and may be cited as the "Physician's Assistants Practice Act."



*Section 3.* "Physician's assistant" means any person not a physician who is certified to perform medical procedures under the supervision of persons licensed to practice under "The Medical Practice Act." A physician's assistant may perform such medical procedures within the specialty of the supervising physician, except that such physician shall exercise such direction, supervision and control over such physician's assistants as will assure that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality. Physician's assistants shall be capable of performing a variety of tasks within the specialty of medical care under the supervision of a physician, although the physician's assistant does not possess the level of medical knowledge necessary to integrate and interpret findings. Physician's assistants cannot exercise independent judgment for purposes of diagnosis and treatment of patients. Nothing in this Act shall be construed as relieving any physician of the professional or legal responsibility for the care and treatment of persons attended by himself or by physician's assistants under his supervision. Physician's assistants shall have only those powers and rights set forth in this Act and the exercise of any powers beyond those set forth shall constitute a violation of this Act.

*Section 4.* No physician's assistant shall use the title of doctor or associate with his name any other term which would indicate to other persons that he is qualified to engage in the general practice of medicine. A physician's assistant shall not be allowed to bill patients or in any way to charge for services. Nothing in this Act, however, shall be so construed as to prevent the employer of a physician's assistant from charging for services rendered by the physician's assistant. The physician shall file with the Department notice of employment and discharge of the physician's assistant at the time of said employment or discharge.

*Section 5.* No more than one physician's assistant shall be employed by a physician. Physician's assistants shall be employed only under the supervision of persons licensed to practice under "The Medical Practice Act" and engaged in private clinical practice, or in clinical practice in public health or other community health facilities.

*Section 6.* Each applicant for a physician's assistant certificate shall:

1. Make application for examination on forms prepared and furnished by the Department of Registration and Education.

2. Submit evidence under oath satisfactory to the Department that:

- (a) He is 21 years of age or over;
- (b) He is of good moral character;
- (c) He has the preliminary and professional education required by this Act;
- (d) He is free of contagious diseases.

3. Designate specifically the name, location, and kind of professional schools, colleges, or institutions attended and the courses which he has satisfactorily completed.

4. Pay to the Department of Registration and Education at the time of application, an examination fee of \$25. The fee for subsequent renewal of a certificate without lapse shall be \$15.

*Section 7.* Except as otherwise provided in this Act, the minimum standards of educational requirements prior to the taking of an examination shall

consist of the following:

- (a) Successful completion of a 4 year course of instruction in a high school, or its equivalent, as determined by the examining committee; and

- (b) Successful completion of a specialized course for physician's assistants consisting of not less than 20 months instruction in any 2 year period; such course and the institution or school offering the same shall be approved by the examining committee provided for in this Act.

The examining committee shall have the power to waive the specialized training provided for in this Section, if the committee determines that any prior training and experience of the applicant is the equivalent of such specialized training.

*Section 8.* Registered nurses in the State of Illinois may take such examination without completing any additional courses of study and shall be issued a certificate upon the passage of such examination.

*Section 9.* Subject to the provisions of this Act, the Department of Registration and Education shall:

1. Promulgate rules approved by the examining committee setting forth standards to be met by a school or institution offering a course of training for physician's assistants prior to approval of such school or institution.

2. Promulgate rules approved by the examining committee setting forth uniform and reasonable standards of instruction, including but not limited to specific subjects taught, to be met prior to approval of such course of instruction for physician's assistants.

3. Determine the reputability and good standing of such schools or institutions and their course of instruction for physician's assistants by reference to compliance with such rules, provided that no school of physician's assistants that refuses admittance to applicants solely on account of race, color, sex, or creed shall be considered reputable and in good standing.

4. Prescribe rules for examining candidates for a certificate as physician's assistant.

5. All examinations provided for by this Act shall be conducted under rules and regulations prescribed by the Department of Registration and Education. Examinations shall be held at least 3 times a year at times and places to be determined by the Department.

No rule or regulation shall be adopted under this Act which allows a physician's assistant to perform any act, task or function primarily performed in the lawful practice of optometry under "The Illinois Optometric Practice Act," approved June 15, 1951, as amended.

*Section 10.* Upon the satisfactory completion of application and examination procedures and compliance with the applicable rules and regulations of the Department of Registration and Education, the Department shall issue a physician's assistant certificate to the qualifying applicant.

*Section 11* The Medical Examining Committee of the Department of Registration and Education as provided in Section 60-a of "The Civil Administrative Code of Illinois," approved March 17, 1917, as amended, may revoke or withdraw the certificate issued under this Act upon any of the following grounds:

1. Conviction in this or another state of any crime which is a felony under the law of this State, or conviction of a felony in a federal court;

2. Gross malpractice resulting in permanent injury or death of a patient;

3. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

4. Habitual intemperance in the use of alcohol, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties.

5. Employment of fraud, deception or any unlawful means in applying for or securing a certificate as a physician's assistant;

6. Exceeding the authority delegated to him by his employing physician;

7. A violation of any provisions of this Act or of the rules and regulations formulated for its administration.

*Section 12.* No action of a disciplinary nature which is predicated on charges alleging unethical or unprofessional conduct of a person who practices as a physician's assistant and which can be reasonably expected to affect adversely that person's maintenance of his present, or his securing of future, employment as such a physician's assistant may be taken by the Department of Registration and Education, by any association, or by any person unless the physician's assistant against whom such charges are made is afforded the right to be represented by legal counsel of his choosing and to present any witness, whether an attorney or otherwise, to testify on matters relevant to such charges.

*Section 13.* Certificates may be revoked or suspended only in the manner provided by Section 60b through 60h inclusive of "The Civil Administrative Code of Illinois," approved March 7, 1917, as now or hereafter amended.

*Section 14.* All final administrative decisions of the Department of Registration and Education are subject to judicial review pursuant to the provisions of the "Administrative Review Act," approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined in Section 1 of the "Administrative Review Act."

*Section 15.* All certificates issued under this Act must be renewed every 2 years after their issuance and the examining committee may require a physician's assistant to submit to a mental or physical examination at any time felt necessary by the examining committee.

*Section 16.* No person shall use the title or perform the duties of "physician's assistant" unless he is a qualified holder of a certificate as provided in this Act. A certified physician's assistant shall wear on his person a visible identification indicating that he is certified as a physician's assistant while acting in the course of his duties.

*Section 17.* The Medical Examining Committee of the Department of Registration and Education shall review the provisions of this Act to determine its effectiveness and accomplishments and shall solicit the cooperation and advice of such public and private agencies as the Committee may deem proper. The Committee shall report its findings and recommendations to the Governor and the General Assembly on January 1, 1980.

*Section 18.* This Act takes effect July 1, 1976.

*Section 19.* This Act is repealed on June 30, 1981.

## Other Examining Boards

Other examining boards operating under the jurisdiction of the Department of Registration and Education are:

### *Dental Examining Committee*

Thomas V. Powell, D.D.S.  
John J. Kelly, D.D.S.  
Silas P. Jones, D.D.S.  
Richard A. Kozal, D.D.S.  
Ogden Munroe, D.D.S.  
Kermit C. Miller, D.D.S.  
George P. Shevlin, D.D.S.

### *Committee of Nurse Examiners*

Jean Lytle  
Charlotte P. Anders  
Dorothy Habben  
Sylvia Mitchell  
Margaret J. Stafford  
Christopher Hannan

### *Nursing Home Administrator Examining Committee*

Del Kinney  
Russell Bryant  
Russ Zimmerman  
Evelyn Johnson, R.N.  
Michael Werckle, M.D.  
Neil Gaynes  
Nathan Helman

### *Illinois Optometric Examining Committee*

Robert W. Stoelzle, O.D.  
Henry R. Moore, O.D.  
Frank F. Sakamoto, O.D.  
Richard L. Stratton, O.D.  
Harold Davis, O.D.

### *State Pharmacy Board*

Milton G. Christy  
Henry Cade  
Raymond Haraburda  
Eugene F. Kaelin  
Clarence Charles Lev  
Philip Sacks  
Prof. Martin I. Blake

### *Physical Therapy Examining Committee*

William Dohse  
Mary Liedloff  
Eugene J. Rogers, M.D.  
John J. Mustari  
Frank Tremaroli

### *Podiatry Examining Committee*

Lowell S. Weil, D.P.M.  
Seymour Kessler, D.P.M.  
Stuart J. Ruch, D.P.M.

### *Psychologist Examining Committee*

Dr. Frank Costin  
Johanna Krout Tabin  
Herbert K. Lotz



## DIVISION OF VOCATIONAL REHABILITATION

623 East Adams Street  
Springfield, IL 62706  
Marlene A. Nelson, *Acting Director*

The Board of Vocational Rehabilitation is a statutory body, established to administer, through one division, the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act, as amended.

### Board of Vocational Rehabilitation

John B. Davis, *Chairman*  
9501 Tripp, Skokie 60076

Stephen Benson  
Chicago 60614

Catherine Condon  
Urbana 61801

John B. DeFrancesco  
Deerfield 60015

Rosalind Durham  
Oak Park 60312

Edward Eagle, Ph.D.  
Evanston 60201

Clarence Noldon  
East St. Louis 62204

Jack Powell  
Hines 60141

Charles Smith  
Markham 60426

Judy Williams  
Golden Gate 62843

Rose Wilson  
Tinley Park 60477

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## Medical Legal Information

(Prepared by ISMS Legal Counsel)

*The purpose of this article is to present the Illinois medical community with a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations. It should not be construed as presenting legal opinion, rather general considerations.*

### ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a general counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries made by the component county medical societies when they are of general interest to the medical community. Although

the Illinois State Medical Society does not provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice.

## THE PHYSICIAN-PATIENT RELATIONSHIP

### *Contractual Relationship*

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be agreed between the physician and the patient.

Whenever possible, the physician should discuss his fee with the patient in advance of treatment. If feasible, the understanding as to the fee should be reduced to writing as a permanent record for both parties. Not only does such a procedure minimize misunderstanding, but it may help to re-emphasize to the patient, and his carrier, the specific contractual duties that the patient has undertaken. In the absence of a specific fee agreement, a physician is entitled to "reasonable compensation" for services rendered by him.

While, as has been indicated above, a physician is free to determine who will be his patients, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so long as the case requires attention. To disregard this

duty may constitute negligence or malpractice on the part of the physician.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;
2. The patient may discharge the physician;
3. The relationship may end by mutual consent;
4. The physician may legally terminate his services if the patient breaks the contract by failing to observe the medical directives of the physician.

In the event the patient fails to follow the physician's advice, the duties of the attending physician do not immediately terminate. Rather, the attending physician must provide the patient with sufficient, reasonable notice of his intention to withdraw, so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured.

## HOSPITAL PATIENT RECORDS

Illinois law provides that every public and private hospital in the State shall, upon the written demand of any discharged patient, permit that patient, the pa-

tient's physician or authorized attorney to examine and make copies of his hospital records. These disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship.

## NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill will result in liability if the patient is thereby injured.

Recently, there has been a tendency (especially in the larger cities) to expand liability and to increase the amounts of recovery once liability has been established. When a sympathetic jury views an injured patient, it may well be inclined to interpret the facts in a manner detrimental to the physician. Although the "reasonable skill" standard is not unduly harsh, it is flexible enough to make its application in a particular lawsuit quite subjective.

While the legal implications in the field of malpractice litigation are numerous in scope, the physician is liable for his own negligent acts and the negligent acts of all employees subject to his control or supervision while acting within the scope of their employment. In the case of a partnership, he is also liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. While the cost of various types of malpractice insurance coverage is costly and still increasing, it is nonetheless recommended that high limits be maintained in one's policy.

In addition to purchase of malpractice insurance, each physician should attempt to conduct his practice in such a fashion that the initiation of (and the finding of "guilty" verdicts in) malpractice litigation is greatly minimized.

The American Medical Association has published and prepared for distribution a pamphlet entitled "Professional Liability and the Physician." Twenty guidelines for preventing malpractice actions are set forth in that

pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.
2. The physician must know and exercise his legal duty to the patient.
3. The physician must avoid destructive and unethical criticism of the work of other physicians.
4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.
5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.
6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.
7. The physician must refrain from over-optimistic prognoses.
8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.
9. The physician must unfailingly secure an "informed"



consent (preferably in writing) for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience, except after a reasonably complete explanation of the procedure and its risks and possible complications; and after obtaining a signed consent from the patient and from the patient's spouse, if the patient is married. Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the patient and preferably with the informed consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In the October, 1971, issue of the *Illinois Medical Journal*, legal counsel to the Illinois State Medical Society expanded upon the recommendations of the AMA and urged that Illinois physicians also observe the following preventative safeguards:

1. Physicians should conduct their practice in hospitals so that they comply with, and live up to, the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act, and the by-laws of the hospital in which they are practicing.

2. Physicians should keep up on modern medicine in the fields in which they practice so they are conversant with and use the latest proven developments.

3. Physicians should call in specialists whenever the need arises.

4. Physicians should provide for automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him, or the specialist in a given field called in by him.

5. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that cases frequently are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.

6. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit, and would not come to trial for a considerable period of time after the alleged injury had taken place.

7. Physicians should carry adequate malpractice insurance.

## ILLINOIS CONTROLLED SUBSTANCES ACT

Under the Illinois Controlled Substances Act, physicians who prescribe or dispense various controlled substances are required to register with the Illinois Department of Regis-

tration and Education. Categories of drugs under which registration is required are almost identical to those established by the Federal DEA.

## LIMITS ON LIABILITY—SPECIAL SITUATIONS

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who, in good faith and without prior notice of the illness or injury, provide emergency care without fee to a person, shall not, as a result of acts or omissions, except wilful or wanton misconduct, be liable for civil damages.

The Medical Practice Act further provides that any physician, serving on any medical utilization committee, medical review committee, or peer review committee shall not be liable for civil damages as a result of his acts, or omissions, or decisions in connection with his duties on such committee, except those acts, omissions or decisions which involve wilful or wanton misconduct.

## AUTOPSY

The *Illinois Revised Statutes* specifically detail the conditions under which a physician may perform an autopsy. Essentially, an autopsy may be performed provided:

1. The physician has a written authorization from the decedent to do so; or
2. The physician has a written authorization from a

surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right (a "surviving relative" means the spouse, an adult child, the parent, or an adult brother or sister of the decedent); or

3. The physician has a telegraphic or telephonic au-

thorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right. This last provision is conditioned, however, upon the requirement that the telegraphic or telephonic authorization is verified, in writing, by at least two persons who were present at the time and place the authorization was received.

Illinois law specifically provides that where two or more persons have equal right to determine the method for disposing of the body, the authorization of only one such person shall be necessary, unless, before the autopsy is performed, any others having such equal right shall object in writing or, if not physically present in the community where the autopsy is to be performed, by telephonic or telegraphic communication to the physician by whom the autopsy is to be performed.

## CONSENT OF MINORS TO MEDICAL TREATMENT

**Birth Control Services for Minors:** Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor: who is married; who is a parent; who is pregnant; who has the consent of parent or legal guardian; as to whom the failure to provide such services would create a serious health hazard; or who is referred for such services by a physician, clergyman or a planned parenthood agency.

**Venereal Disease and Drug Use—Consent to Treatment By Minor:** Illinois law specifically provides that a minor, 12 years of age or older, who may have come into contact with any venereal disease or who is suffering from the use of depressant or stimulant drugs or narcotic drugs (as defined in Controlled Substances Acts), may give his or her own binding consent, which is not later voidable, to

While authorization may be given to a physician or hospital administrator or his duly authorized representative, only a physician shall perform the autopsy. The authorized personnel of a hospital or other qualified personnel selected by a physician may assist a physician performing an autopsy.

The term "written authorization", provided for above, means any printed, typed or handwritten communication signed by the person granting the authorization.

It is important to emphasize that, in Illinois, the heirs and next of kin can bring an action for mutilation of the body of a decedent in those cases in which an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed when ordered by the coroner or upon the appropriate written consent of the next of kin as specified above. (The coroner may order an autopsy directly against the wishes of the next of kin).

the furnishing of medical care or counselling related to the diagnosis or treatment of such disease. Each incident of venereal disease shall be reported to the State Department of Public Health or the local board of health in accordance with regulations that may be so adopted. Illinois law specifically states that the consent of the parent, parents, or guardian of such minor, receiving such treatment or counselling, shall not be necessary to authorize the care or counselling which is related to the diagnosis or treatment of such disease or drug or narcotic use.

Any physician who provides diagnosis or treatment to a minor patient who has come into contact with any venereal disease or suffers from the use of any drug or narcotic, referred to above, may, but shall not be obligated to, inform the parent, parents or legal guardian of any such minor as to the treatment given or needed.

## CATEGORIES OF MINORS WHO MAY, BY LAW, GIVE CONSENT TO ANY AND ALL MEDICAL TREATMENT

**Parental Consent for Treatment of a Minor Child When Parent is Also a Minor:** Illinois law provides that any parent, including a parent who is a minor, may give his or her consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority, and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

The consent to the performance of a medical or surgical procedure, by a physician licensed to practice medicine and surgery, which is executed by a married person who is a minor, by a pregnant woman who is a minor, or by any person 18 years of age or older, is not voidable because

of such minority, and Illinois law further provides that for such purpose, such married person, who is a minor, such pregnant woman, who is a minor, or such person 18 years of age or older is deemed to have the same legal capacity to act and has the same powers and obligations as has a person of legal age.

**Situations Where Consent Need Not Be Obtained For Treatment of a Minor:** Whenever a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor's health.

## UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law has recently been expanded so that it now includes coverage by physicians who employ only one person. This liability was discussed at some length in the "Practice Management" section of the July, 1973, issue of the *Illinois*

*Medical Journal*. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.



## BLOOD LABELING

The Illinois Blood Labeling Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;

2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or during the administration of that blood by transfusion;

3. As of July 1, 1973, no blood (which has been initially acquired by purchase) may be administered by transfusion in Illinois unless:

- a. The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered to that patient; and
- b. The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

## IMMUNIZATION

In 1972, legislation was passed to eliminate the requirement of smallpox immunization and to add rubella to the list of diseases against which there must be immunization.

The 1973 session of the Illinois General Assembly, however, eliminated a listing of specific diseases against which there must be immunization and transferred responsibility

for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations, which may change from time to time, as to those diseases against which children will be immunized. This affects the School Code and the Communicable Disease Act.

## MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. Historically, a primary reason for forbidding the use of the corporate form for doctors was that the personal assets of a corporation's stockholders were traditionally beyond the reach of creditors, including persons injured by the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability.

The corporate form did, however, present certain advantages, particularly in the area of taxation, for which there was no compelling reason to discriminate against professionals. Throughout the past two decades the tax status of various professional medical corporations were thrashed out among the Internal Revenue Service, the Federal courts and professionals who claimed that their businesses were entitled to be taxed as corporations. Although many legal questions still remain unresolved, it is now reasonably certain that physicians in Illinois can take advantage of the corporate form.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

Tax consequences are the primary factors in determining the wisdom of incorporation. In an article written for the November, 1970, issue of the *Illinois Bar Journal* Linscott R. Hanson summarized the advantages and disadvantages of incorporation. Among the major advantages listed, were:

1. Deductibility by employees of a portion of their sick pay.
2. Deductibility as a corporate business expense of the full cost of employee accident and health insurance.
3. Deductibility as a corporate business expense of medical payments in excess of insurance.
4. Lower corporate tax rates for funds to be re-invested in the business.
5. Relatively easy adjustment of ownership percentages.
6. Avoidance of many probate problems upon the death of a practitioner and the avoidance of having to create a whole new business as when a partner dies.
7. Liability limitation, other than for malpractice, to the investment in the corporation thus reducing investors' risks.
8. Miscellaneous pension and profit-sharing tax advantages.

The disadvantages listed by Hanson included:

1. Possible legal costs in defending, to the Internal Revenue Service, the corporate status.
2. An increase of up to 25% for Social Security costs.
3. Corporate franchise taxes.
4. Possible subjection in fact to capital stock and personal property taxes.
5. Increased administrative and legal costs.
6. Increased state income tax payments.
7. State licensing fees.
8. Subjection to a host of State and Federal regulations of corporations.

Certainly each practitioner, physician and partnership should consider the merits of incorporating. The purpose here has been to give a brief explanation so that each interested physician can receive a general over-view of his options. A tax specialist should, of course, be consulted to review the particulars of each business situation.

## **MDs EXCLUDED FROM 'CERTIFICATE OF NEED' CONTROLS**

Plans to build, expand, move or sell a hospital, nursing home or surgicenter require approval of the State Comprehensive Health Planning (CHP) Agency.

A provision in the original bill which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn because of vigorous ISMS opposition.

This law covers construction or modification plans involving an expenditure of more than \$100,000, or a substantial change in services or bed capacity. In effect, facilities covered by the "certificate of need" umbrella

will be shifted into a semi-public utility status.

Local CHP operations are to hold public hearings on all applications for construction or expansion of facilities before submitting a recommendation to the state CHP board for final action. The State CHP agency is required to study: (1) area size; (2) population and growth potential; (3) number of existing and planned facilities offering similar services; (4) utilization of existing facilities; (5) availability of alternative facilities and services before granting approval; and (6) availability of necessary personnel.

## **REGULATE HMO DEVELOPMENT, SERVICES**

A nine-member Health Maintenance Advisory Board within the Illinois Department of Public Health (IDPH) will develop standards governing the quality of services provided by Health Maintenance Organizations (HMOs).

Under S.B. 1128, IDPH also will evaluate an HMO

applicant's ability to meet these standards and refer its findings to the Illinois Department of Insurance which grants HMO certification. In addition, IDPH will be required to conduct annual reviews of HMO services.

## **INSURANCE AND CLAIM FORMS**

Various forms are used for submitting claims, either for reimbursement of the insured or on assignment. Generally speaking, these forms are related to the coverage purchased and the contract of the insured with a carrier. Physicians are cautioned to provide only such information as that to

which they can personally attest, and that there is not granted a blanket authority for reimbursement of services performed by another professional when the physician has not personally seen the patient.



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# *Illinois Delegation to the American Medical Association*

## **Report to the Membership**

The Illinois Delegation to the American Medical Association submitted 10 resolutions for consideration by the AMA House of Delegates in June. Following is the action taken on these resolutions:

### **Resolution 73— Catastrophic Health Insurance**

This resolution, which asked the AMA to draft model state bills on voluntary catastrophic health insurance, was one of a number of items related to national health insurance. The House adopted a substitute that continued AMA support of HR 6222 for the provision of both basic and catastrophic coverage where such is needed and registered its concern regarding the present enormous cost and always-increasing regulatory control inherent in medical care programs administered under government, pointing out that the true additional cost of any program for total nationalization of the American health system at this time could cause runaway inflation and lead to a national economic crisis. The Board of Trustees was directed to study requests that AMA foster the expanded availability of appropriate coverage through voluntary private insurance and proceed forthwith to design, have introduced and seek passage of legislation to provide for universally available catastrophic insurance coverage financed through and administered by the private health insurance industry.

### **Resolution 74—Prolonging Human Life**

This resolution called for establishment of a policy of opposition to legislation that might restrict or interfere with a physician's medical judgments. It was considered with a resolution which emphasized the applicable ethical principles related to terminal illness. The substitute adopted reaffirmed established policy: (1) statutory definition of death is neither desirable or necessary; (2) death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria; (3) permanent and irreversible cessation of function of the brain constitutes one of the various criteria which can be used in the medical

diagnosis of death; (4) physicians may and indeed should be encouraged to discuss death and terminal illness with patients; (5) the cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that death is imminent is the decision of the patient and/or his family, and (6) the advice and judgment of the physician should be freely available to the patient and/or his immediate family. The Judicial Council was requested to review the above policy positions in the light of recent legislative and judicial actions and report back to the House in December with recommendations for any changes needed to provide additional guidance to physicians and medical societies.

### **Resolution 75—Fiscal Notes as Part of Federal and State Health Programs**

This resolution asked the AMA to encourage enactment of legislation requiring fiscal notes as part of every federal and state health program. It was considered with a resolution asking the AMA to draft a bill for introduction in the Congress and a model bill for introduction in state legislatures which would specifically identify the cost of the legislation to third parties. Both were referred to the Board of Trustees for study as to feasibility and desirability.

### **Resolution 76—Prescribing Eye Medications**

The House adopted a substitute resolution reaffirming its policy that only physicians licensed to practice medicine and surgery in all its branches are qualified to prescribe or apply eye medications and urged state medical societies to oppose any legislation or administrative attempt to give optometrists a license to prescribe or apply medications or to diagnose disease or injury or to diagnose the absence of disease or injury.

### **Resolution 77—Electromyoneurographic Procedures and Examinations**

This resolution asked the House of Delegates to recognize clinical electromyoneurographic examinations as a procedure that only physicians



may perform and to urge component societies to request state boards of medical license to investigate and take appropriate action when such examinations are performed by persons not licensed to practice medicine in all its branches. The House amended the resolution to allow such examinations to be performed only by or under the supervision of physicians licensed to practice medicine in all its branches and trained in these procedures.

#### **Resolution 78—Reduction of CHAMPUS Fees**

This resolution called attention to the recent change in CHAMPUS payment levels from a payment approaching usual and customary or reasonable to application of the Medicare payment formula, including the 75th percentile and the year or more time-lag in recognizing changes in charges and asked the Association to seek a change in the CHAMPUS policy. In addition to negotiating with the Department of Defense a "no rollback" of CHAMPUS fees below current levels and seeking return to the previous intermediaries for payment of usual and customary fees, the AMA will urge its members treating or caring for CHAMPUS beneficiaries to bill their patients directly, explaining that they are being forced to direct bill because of the unfair, unilateral action of the Department of Defense in reducing physicians' fees.

#### **Resolution 79—Reimbursement of Physicians Performing Utilization Review on Medicare Patients**

This resolution asked the AMA to seek changes in Medicare reimbursement practices which pay for Medicare utilization review only if all hospital patients are subject to such review. It was noted that PL 94-182 does permit payment for PSRO review of Medicare-Medicaid patients only, but that this amendment does not apply to Medicare where there is no PSRO operation. The AMA will seek changes in these discriminatory reimbursement practices of the Social Security Administration in connection with utilization review of Medicare patients.

#### **Resolution 80—PSRO Amendments**

This resolution directed the AMA to identify all necessary and desirable amendments to the PSRO law, to publicize these amendments, and present progress reports on each of the proposed

amendments periodically over the next two years. The Board of Trustees was directed to implement this procedure.

#### **Resolution 81—PSRO Participation in Designated Areas**

This resolution called for establishment of an ad hoc committee of the Council on Medical Service to parallel its existing Ad Hoc Committee PSRO. This new committee would represent MDs on areas where PSROs have not been formed and aid them in establishing a unified PSRO. It was pointed out that the current Ad Hoc Committee on PSRO is charged with offering appropriate assistance to physicians involved in implementing the PSRO program and that this charge allows the committee to provide the assistance requested in Resolution 81. It was, therefore, not adopted.

#### **Resolution 82—Unified Membership**

This resolution proposed that the Board of Trustees assist efforts to maintain existing unified memberships by providing certain specific information on AMA benefits. The House adopted a substitute which directed that the AMA provide all feasible and reasonable services, in keeping with the federation concept, to state associations that seek assistance for their efforts to maintain or accomplish unified membership.

#### **Illinois' Role on Reference Committees**

Illinois, with its 14 delegates, plays a significant role in the business of the AMA House of Delegates. It is quite evident that the delegation has reached a new peak of leadership. In at least six instances, other delegations cleared their amendments with Illinois before presenting them to the House in Dallas.

The size of the Illinois delegation makes it possible to have indepth monitoring of all nine reference committees—an advantage enjoyed by few other states.

Members of the delegation who attended these reference committee hearings have listed the significant actions that should be called to the attention of ISMS members:

#### **Constitution & Bylaws**

New amendments assure complete independence of executive, legislative and judicial branches of the association. Members of the

Judicial Council may not serve as a delegate, alternate delegate, general officer or be a member of any council or committee of the AMA. Size, purpose and tenure for eight standing councils of the AMA were established. These are Constitution & Bylaws, Judicial, Medical Education, Medical Service, Scientific Affairs, Legislation, Continuing Physician Education, and Long-Range Planning and Development. Five councils will be elected by the House; Legislation and Continuing Physician Education will be appointed by the Board, and Long-Range Planning and Development will be appointed jointly by the Speaker of the House and the Board of Trustees. The office of vice president of the AMA is to be eliminated.

### Reference Committee A

Report E, of the Council on Medical Service, adopted by the House, indicates why freestanding catastrophic health insurance is not acceptable:

"The council must emphasize again, as it has in the past, that both Blue Cross/Blue Shield and HIAA representatives still hold that 'catastrophic coverage' makes sense only with a foundation of sound basic coverage. The basic program, a BCA representative pointed out, is 'where the benefit need and demand are greatest.' Freestanding catastrophic programs lead to a shift of basic benefits into the catastrophic structure, destructive to both the basic and the catastrophic approach."

"The council does not believe that a special task force need be appointed to meet with health insurance industry representatives, considering existing liaison arrangements effective in most instances, nor does it believe the Association can properly seek or assist in the formulation of freestanding catastrophic coverage plans. Catastrophic coverage is most effective and inexpensive when combined with adequate basic health insurance. The council also recognizes that the private insurance industry is, in fact, continually and effectively working to increase the number of individuals covered under one or another form of comprehensive (basic plus catastrophic) health insurance, with the long-time support and encouragement of this Association."

The House rejected a report of the Council on Medical Service which would designate the specialties of family practice, internal medicine, pediatrics and obstetrics-gynecology, together with general practice, as major providers of primary care. The report was not accepted because it was contended that in Europe only a few categories can be the "portal of entry" into the health care system and that recognition of the four specialties might preclude the direct access

by patients to any personal or consulting physician of their choice.

### Reference Committee B

The Council on Legislation has devised model legislation to be used as a guide for states' legislatures in providing for the confidentiality of health care information and has developed two model bills for use by state associations in devising medical disciplinary bills. All resolutions and reports dealing with national health insurance and the National Health Planning and Resources Act were referred to the Board of Trustees.

### Reference Committee C

Report A of the Council on Medical Education, adopted by the House, outlines discussions and studies currently being conducted by the Council on Medical Education, its advisory committees and the Liaison Committee on Graduate Medical Education to assure that physicians entering specialty education will have sound knowledge of all major fields of clinical medicine prior to more specialized education.

Report D of the Council on Medical Education, which was referred back to the council for additional study and report to the House, is concerned with increasing medical school tuition and the difficulties students are having in financing a medical education without adequate federal funding of loan programs.

Resolution 101, adopted by the House, alluded to recent dissatisfaction with evaluations and recommendations by residency review committees with respect to the presence of full-time program directors and/or medical school affiliations, and requested the AMA to adopt the policy that evaluation and approval of residency programs should be based on the educational quality of the program and not on administrative and organizational requirements.

Resolution 116, referred to the Board of Trustees, asked for a review of the status, availability, distribution and number of part-time residencies.

Resolution 100 describes the success and effective operation of state medical associations in improving programs on continuing medical education in their areas and their concerns that the establishment of the Liaison Committee on Continuing Medical Education may adversely affect the process of accreditation developed by the Council on Medical Education. As a result, the



House adopted the position that the AMA supports the principle that the Liaison Committee on Continuing Medical Education continue to follow the procedure now used by the AMA of accepting the recommendation for accreditation made by the state medical associations.

#### **Reference Committee D**

The House added the following to the six essential characteristics which must be demonstrated to assure validity and effectiveness of medical audits:

Release of specific medical audit reports beyond the medical staff structure is not advised. Attempts by other components of the hospital to obtain these reports over the objections of the medical staff should be reported immediately to the JCAH.

The report was filed with the request that the Board of Trustees instruct the Committee of AMA Commissioners to seek an amendment to hospital accreditation standards that makes it clear that the report by the hospital medical staff to the hospital board on the medical staff's quality care activities is not required to be the specific findings of medical audit except where corrective board action is required, but that a summary of the extent and character of the review of clinical care is otherwise sufficient.

Resolution 59, adopted by the House, presented these principles to be followed in the delineation of medical staff privileges:

(1) A purpose of delineating privileges is to provide broad guidance to those persons with a legitimate interest in information regarding the general field of competence of members of the medical staff; (2) Granting privileges in a recognized medical specialty or specialties should imply competence in those procedures generally recognized as being within the scope of that specialty or specialties without the need for the medical staff to paraphrase in whole or in part the limitations of that specialty; (3) A medical staff, when it believes such action appropriate to best serve the interest of the public and with reason may extend or restrict a staff member's privileges with or without the approval or request of the staff member, subject to due process; (4) When any member of the medical staff has demonstrated his competence by his past record of training and experience, and the medical staff believes he is capable of performing in the same competent manner in the future, great care should be exercised by the medical staff in setting a policy for delineation of privileges, that the policy does not make any member hesitant to perform procedures for which he is qualified through fear of malpractice suit for failure to conform to that policy, and (5) The AMA representatives to the Joint Commission on Accreditation of Hospitals should be guided by this policy

when formulating guidelines for medical staff bylaws and in forming JCAH policy on delineation of privileges for members of medical staffs.

#### **Reference Committee E**

The House adopted the following policy on viewing television violence:

(1) TV violence is a risk factor threatening the health and welfare of young Americans, indeed our future society; (2) the AMA commits itself to remedial action in concert with industry, government and other interested parties, and (3) the AMA encourages all physicians, their families and their patients to actively oppose TV programs containing violence, as well as products and/or services sponsoring such programs.

The House referred to the Board of Trustees and Council on Medical Service the following statement on "unnecessary" surgery:

The American Medical Association reaffirms the right of a patient or a physician to seek consultation freely with any consultant of his choice. If consultation is mandated by a third party payor, it shall be improper for the consultant to assume direct or indirect control of the patient's further care in the case, or to be paid fees for services beyond that of his consultation. The terms "necessary" or "unnecessary" when applied to surgery have little or no value without more exact definition. Difference of opinion among physicians is not a criterion of unnecessary surgery.

#### **Reference Committee F**

The House commended the Board of Trustees for its previous actions and its continuing attention to the matter of federally mandated utilization review, and instructed the Board to take appropriate action, including further legal action if necessary, to protect the quality of care and to insure against federal intervention into the physician-patient relationship when final utilization review regulations are published.

#### **Reference Committee G**

A special committee of the House of Delegates on membership opinion polls was reactivated to review requests for polling the membership.

#### **Reference Committee H**

ISMS was one of three state associations commended for their support of physicians initiating countersuits against lawyers and plaintiffs who file non-meritorious professional liability lawsuits. The AMA will encourage other state so-

cieties to give appropriate assistance to physicians in initiating and pursuing carefully selected, meritorious counter-suits.

### Highlights

Highlight of the Dallas meeting for Illinois was the first ballot reelection of Dr. Frank J. Jirka, Jr., to a full three-year term on the AMA Board of Trustees. Dr. Jirka was elected to a two-year term on the Board in 1974.

All 14 delegates attended the meeting and the following served on reference committees:

Dr. H. Close Hesseltine, Committee B, Dr. Howard C. Burkhead, Committee E, and Dr. Edward A. Piszczek, Committee G. Dr. Fredric D. Lake served as a teller. Dr. Robert R. Hartman substituted as an alternate delegate for Dr. Eugene P. Johnson.

Edward A. Piszczek, M.D.  
Chairman

Jack Gibbs, M.D.  
Secretary

---

## *With all due respect to Thomas Jefferson—*

WHEN in the course of human events it becomes necessary for . . . people to dissolve the political bands. . .

We hold these truths to be self-evident, that all men . . . are endowed with certain unalienable rights, that among these are . . . liberty . . .

. . . all experience hath shown that mankind are more disposed to suffer, while evils are sufferable, than to right themselves by abolishing the forms to which they are accustomed. But when a long train of abuses and usurpations, pursuing invariably the same object evinces a design to reduce them under absolute despotism, it is their right, it is their duty, . . . to provide new guards for their future security.

Such has been the patient suffering of these *physicians* and such is now the necessity which constrains them to alter . . . the system. . . . To prove this, let facts be submitted to a candid world.

*The Government* has called together legislative bodies at a place . . . distant from the depository of their public record, for the sole purpose of fatiguing *the public* into compliance with *oppressive* measures.

*The Government* has erected a multitude of new offices and sent hither swarms of officers to harrass our people and eat out their substance.

*The Government* imposes *tasks* on us with-

out our consent.

*The Government* is taking away our charters, abolishing our most valuable laws, and altering fundamentally the forms of *medical practice*.

*The Government* has excited domestic insurrections amongst us, and has endeavored to bring on the inhabitants . . . (as) an undistinguished destruction of *medicine*.

In every stage of these oppressions we have petitioned for redress in the most humble terms: our repeated petitions have been answered only by repeated injury. A *Government* whose character is thus marked by every act which may define a tyrant, is unfit to be the *provider of health care* for a free people.

We, *physicians*, therefore assembled, . . . do in the name, and for . . . the good of *the people*, . . . solemnly publish and declare that physicians are, and of right ought to be, free. . . . that *we* are absolved from all *servitude* to the *Government*, and that all political connection between *us* and *the Government* is and ought to be totally dissolved; and that as free and independent *physicians* we have the *obligation* to do all acts and things which *we have an obligation to do as physicians*.

And for the support of this declaration, . . . we mutually pledge to each our lives, our fortunes and our sacred honor.



# Doctor's News

**COUNTERSUIT UPDATE**—Post trial motions requesting a new trial for vacating judgement in the Berlin case were denied. On September 8, 1976, an appeal was filed with the First District Appellate Court on behalf of the defendant attorneys.

**NCI GUIDELINES AVAILABLE**—The National Cancer Institute (NCI) has issued suggested guidelines for treatment of patients with a history of head and neck irradiation during childhood or adolescence. The guidelines parallel those distributed last year to Illinois physicians by the ISMS-Illinois Hospital Association Joint Committee on Thyroid Neoplasms Associated with Head and Neck X-Radiation.

A synopsis of the NCI guidelines is presented in the May-June issue of *Ca—A Cancer Journal for Clinicians* (Vol. 26, No. 3, pp. 150-165), "Information for Physicians on Irradiation-Related Thyroid Cancer" and "Thyroid Cancer—Iatrogenic and Otherwise." The ISMS-IHA guidelines are available from ISMS. Contact the Division of Public Relations, 55 E. Monroe, Suite 3510, Chicago 60603; or phone (312) 782-1654.

**TREATMENT STUDY ON ANOREXIA NERVOSA** sponsored by NIMH, is being conducted by the Research Department of the Illinois State Psychiatric Institute. Patients age 13-40, who qualify for a diagnosis of anorexia nervosa, including substantial weight loss due to deliberate restriction of food intake or vomiting with pleasure, amenorrhea, and other secondary signs of starvation, are treated for a 6-week period. They receive careful medical supervision, psychotherapy, periactin and behavior therapy and follow-up therapy, including family therapy. For information call: Regina Casper, M.D. (312) 314-8000 or John M. Davis, M.D. (312) 341-6302.

**DONATIONS TO SUPPORT SWINE FLU MASS CLINICS**—Legal Counsel of the Center for Disease Control has recently stated that under the new federal legislation providing liability protection for volunteer program participants, donations to support mass clinic expenses may be accepted. However, "to the extent that there is any suggestion of compulsion or requirement for payment, there is a risk that the protection of the statute will be lost." Expect close scrutiny of any donation cases to determine the compliance with the no-charge requirement of the law.

**MIRACLES WILL NEVER CEASE**—A new "miracle" allergy treatment—Autogenous Urine Immunization Therapy—may soon reach Illinois. The treatment, involving a series of 8 injections of the patient's own laboratory treated urine is supposed to protect the body against any invading substance. The "Allergy Control Foundation," a California operation, is promoting clinics offering this treatment.

**TRANS-PANAMA CANAL AIR/SEA CRUISE**—Choice cabins are available on January 5-14, 1977. Cabin prices begin at \$998. For further information contact Perry Smithers or Betty Duffy at Society Headquarters.

**AAMA HOLDS 20th ANNUAL CONVENTION IN CHICAGO**—The American Association of



Medical Assistants celebrated the 20th anniversary of its organization at the Palmer House from September 13, through September 18. Dr. Joseph Skom, ISMS President, gave the welcome address at the opening session of the House of Delegates. Pictured with Dr. Skom (center) are Norma Domanic, General Chairman for the AAMA Convention (left), and Jean Berschinski, Vice Chairman for the Convention.

**PHYSICIANS IN THE NEWS**—The highest academic research degree, Doctor of Science, has been conferred by the University of London, England, upon **Dr. Velayudhan Nair**, of the University of Health Sciences/Chicago Medical School. **John W. Mason, M.D.**, has been appointed chairman of the Christ Hospital department of pathology. He will also be chairman of the pathology departments of the other Evangelical Hospital Association hospitals. Dr. Mason comes to Illinois from Berkshire Medical Center and Hillcrest Hospital in Pittsfield, Massachusetts. **Peter Rosen, M.D., Glencoe**, has been appointed to a two-year term on the American Board of Emergency Medicine. Dr. Rosen is professor and director of the Division of Emergency Medicine and director of the emergency residency program at University of Chicago. **Galdino Emilio Valvessori, M.D.**, professor of medical radiology at the University of Illinois College of Medicine, has been chosen as president-elect of the International Collegium of Radiology and Otolaryngology.

New officers have also been elected for the Chicago Society of Industrial Medicine and Surgery for the coming year. They are **Harry C. Coblens, M.D.**, president; **Robert S. Kassriel, M.D.**, vice president; **Bille Hennan, M.D.**, secretary; and **John M. Staron, M.D.**, treasurer. New members of the society's Board of Governors include **Lawrence Bowness, M.D.**, **John W. Kaminski, M.D.**, **Abraham Koransky, M.D.**, and **Maynard Shapiro, M.D.**

## *Playing Catch Up*

Commenting on a government study of pay of federal civilian workers compared with private industry, the *Chicago Tribune* recently said: "In table after table, graph after graph, the report presents a shocking account of how, in the name of comparability, federal employees have caught

up with private employees in pay and forged far ahead of them in benefits." The study by the General Accounting Office said federal fringe benefits alone cost \$11 billion in 1974 and will probably rise more than double to \$24 billion in eight years.



# Convention Handbook



## INTERIM SESSION '76

**Members of the House of Delegates**

**Delegates and Alternate Delegates to the Illinois State Medical Society**  
**Downstate Delegates**  
**Chicago Medical Society**

**Program Summary by Days**

**Agenda of the House of Delegates**

**Committees of the House of Delegates**

**Resolutions**

*for October, 1976*

# Members of the 1976 House of Delegates

## OFFICERS

President .....	Joseph Skom
President Elect .....	George Wilkins
Secretary-Treasurer .....	Jacob E. Reisch
Speaker of the House .....	James A. McDonald

## TRUSTEES

First District .....	Joseph L. Bordenave	1977	Fourth District .....	Fred Z. White	1979
1A District .....	P. John Seward	1977	Fifth District .....	Paul F. Mahon	1979
Second District .....	Allan L. Goslin	1977	Sixth District .....	Robert R. Hartman	1978
Third District .....	Alfred Clementi	1979	Seventh District .....	Alfred J. Kiesel	1979
	Alfred Faber	1977	Eighth District .....	James Laidlaw	1979
	Robert T. Fox	1979	Ninth District .....	Warren D. Tuttle	1978
	Henrietta Herbolsheimer	1978	Tenth District .....	Julian W. Buser	1978
	Lawrence L. Hirsch	1978	Eleventh District .....	Ross Hutchison	1977
	Eugene T. Hoban	1978	Trustee-at-Large .....	J. M. Ingalls	
	William M. Lees	1977			
	Joseph C. Sherrick	1977			
	Philip G. Thomsen	1977			
	Herman Wing	1979			

## EX OFFICIO

(Privilege of the floor but without the right to vote)

1st Vice President .....	David S. Fox
2nd Vice President .....	Theodore Grevas
Vice Speaker (when not presiding) .....	Cyril Wiggishoff

## Past Presidents

J. Ernest Breed .....	1971	Fredric D. Lake .....	1975
Edward W. Cannady .....	1970	Willis I. Lewis .....	1954
Everett P. Coleman .....	1945-46	Burtis E. Montgomery .....	1966
Newton DuPuy .....	1968	Edward A. Piszczek .....	1965
Harlan English .....	1964	Caesar Portes .....	1967
Edwin S. Hamilton .....	1962	Willard C. Scrivner .....	1974
H. Close Hesseltine .....	1961	Leo P. A. Sweeney .....	1953
C. J. Jannings, III .....	1972	Philip G. Thomsen .....	1969
Frank J. Jirka, Jr. ....	1973	Arkell M. Vaughn .....	1955

## Delegates to AMA

Herschel Browns	Theodore Grevas	Edward A. Piszczek
Howard C. Burkhead	H. Close Hesseltine	John Ring
Carl E. Clark	Maurice M. Hoeltgen	Charles K. Wells
Alfred J. Faber	William M. Lees	Fred A. Tworoger
Jack L. Gibbs	Morgan M. Meyer	

## Past Trustees or Councilors

Earl H. Blair .....	Third District	Eugene P. Johnson .....	Eighth District
Walter C. Bornemeier .....	Third District	Ted LeBoy .....	Third District
Carl E. Clark .....	First District	A. Edward Livingston .....	Fifth District
Samuel Cloninger .....	Third District	Joseph R. O'Donnell .....	Eleventh District
Herbert Dexheimer .....	Tenth District	Mather Pfiennenberger .....	Sixth District
David S. Fox .....	Third District	Ralph N. Redmond .....	Second District
Willard W. Fullerton .....	Tenth District	George Shropshear .....	Third District
George E. Giffin .....	Second District	Darrell H. Trumpe .....	Fifth District
Arthur F. Goodyear .....	Seventh District	Frederick E. Weiss .....	Third District
Lee N. Hamm .....	Fifth District	Charles K. Wells .....	Ninth District
		Paul P. Youngberg .....	Fourth District



# Delegates and Alternate Delegates to the Illinois State Medical Society

## DOWNSTATE DELEGATES

<i>County</i>	<i>Delegates</i>	<i>Alternate</i>	<i>County</i>	<i>Delegates</i>	<i>Alternate</i>
ADAMS	James W. Sutherland	Walter Stevenson, III	LOGAN	Glen E. Tomlinson	James Borgerson
ALEXANDER	Gemo Wong	Chas. Yarbrough	MACON (2)	A. J. Kiessel	C. O. Stanley
BOND	M. K. Kaufman	Boyd McCracken		J. Schrodt	D. Statzer
BOONE	John Steinkamp	M. J. Carlisle	MACOUPIN	Robert G. England	Robert H. Rutherford
BUREAU	Louis Lukancic	James Foresman	MADISON (2)	E. K. DuVivier	Edward Ragsdale
CARROLL	C. G. Piper	L. B. Hussey		George T. Wilkins	Robert F. Hamilton
CASS-BROWN	B. A. DeSulis		MARION	Walter P. Plassman	Hamid Mahmud
CHAMPAIGN (3)	James M. Laidlaw	Frank Kresca	MASON	Jack Means	Donald Stehr
	Harold J. Kolb	Homer Hindman	MASSAC		
	B. Robbins, Jr.	Harlan J. Failor	MCDONOUGH	S. M. Gines	J. S. Goncher
CHRISTIAN	M. T. Salaymeh	R. M. Seaton	McHENRY	August Rossetti	Ted Rolander
CLARK	George Mitchell	Eugene Johnson	McLEAN	Loren Boon	Robert Reardon
CLAY			MENARD	Robert Schaefer	
CLINTON	W. L. DuComb	F. H. Ketterer	MERCER	Monty P. McClellan	James W. Hastings
COLES-			MONROE	Russell W. Jost	E. F. Maglasang
CUMBERLAND	M. W. Hollowell	J. R. Mallory	MONTGOMERY	Lee Johnson	
CRAWFORD	Herb Ikmany	Dean J. Pelley	MORGAN-SCOTT	E. C. Bone	Frank B. Norbury
DEKALB	John Ovitz		MOULTRIE		
DEWITT	Herman Meltzer	Julius Villafior	OGLE	Don E. Hinderliter	Robert F. Dearborn
DOUGLAS	Humberto Mondul	Robert Arrol	PEORIA (3)	G. W. Giebelhausen	Gene O. Hoerr
DUPAGE (7)	Morgan M. Meyer	John V. Ryan		Ernest F. Adams	Carl F. Neuhoff
	J. P. Campbell	Dan P. Butcher		Rex O. McMorris	Thomas W. Clark
	Wm. C. Perkins	Robert Fitzgerald	PERRY	C. E. Cawvey	B. A. Kinsman
	Wm. B. Frymark	Orren D. Baab	PIATT	Wm. E. Mundt	George Green
	Kenneth Hurst	Charles H. Westfall	PIKE	C. B. Lara	T. C. Bunting
	Joseph O'Donnell	Robert D. Dooley	PULASKI	A. L. Robinson	
	Joseph P. McKay	Raymond A. Dieter, Jr.	RANDOLPH	O. W. Pflasterer	J. M. Whittenberg
EDGAR	J. M. Ingalls		RICHLAND	C. A. DeKovessey	Lawrence J. Knox
EDWARDS	Andrew Krajec	Paul Neirenberg	ROCK ISLAND (2)	Richard Arnell	Wm. J. Dougherty
EFFINGHAM				Frank E. Miller	Donald D. Tomlin
FAYETTE	D. H. Rames		ST. CLAIR (3)	H. Frank Holman	Donald L. Jerome
FORD	Edson Etherton	Somchai Supawanich		Charles R. Frazer, Jr.	Joseph M. Dugan
FRANKLIN	John P. Pope	James P. Durham		Thomas P. Meirink	Mays C. Maxwell
FULTON	Jack L. Gibbs	R. H. Maguire, Jr.			
GALLATIN	John E. Doyle		SALINE-POPE-		
GREENE	James C. Reid	Jude A. Caselton	HARDIN	Alex Z. Goldstein	Elliott O. Partridge
HANCOCK	Charles F. Eddingfield	James A. Coeur	SANGAMON (4)	Robert P. Johnson	David B. Lewis
HENDERSON	Silvino Lindo			Edward G. Ference	Twofig M. Arjmand
HENRY-STARK	James Parsons	Wm. D. Larson		Robert L. Prentice	Robert A. Nachtwey
IROQUOIS	Kent Swedlund	James Dailey	SCHUYLER	Gerald Riordan	Ross Schlich
JACKSON	Paul P. Lorenz	Eli L. Borkon	SHELBY	Henry C. Zingher	Robert E. Cox
JASPER			STEPHENSON	Patrick L. Shiels	Duncan Biddlecombe
JEFFERSON-			TAZEWELL	E. L. Vickery	J. S. Berry
HAMILTON	James R. Heersma	H. Goff Thompson, Jr.	UNION	Theofan R. Trifonoff	John B. Sombeck
JERSEY-			VERMILION	Robert Rader	Wm. Whiting
CALHOUN			WABASH	A. M. Taylor	M. C. Spencer
JO DAVIES	Lyle A. Rachuy		WARREN	R. L. Fuller	Wm. Walling
KANE (4)	A. Beaumont Johnson	Erwin Robin	WASHINGTON	Kenneth Ambrose	James W. Marshall
	Robert Barnes	James Pritchard	WAYNE	J. L. Beguelin	
	Wayne Leimbach	Peter Starrett	WHITE	Charles J. Jannings	Arthur R. Marks
	George Shimkus	William Sheehy	WHITESIDE	Phillip Boren	
KANKAKEE	Donald Parkhurst	James Geist	WILL-GRUNDY (3)	John Hubbard	Clarence Mueller
KENDALL	Walter H. Brill			Robert J. Becker	Raymond R. Clemens
KNOX	Homer L. Fleisher	Jerry Ramunis		Guy A. Pandola	Kenneth Uznanski
LAKE (4)	John Ring	Hugh Falls		Merle L. Otto	Albert Wm. Ray, Jr.
	Earl Klaren	Homer Goldstein	WILLIAMSON	Herbert V. Fine	W. R. Malony
	David Helberg	Richard Hawkins	WINNEBAGO (4)	Robert H. Behmer	R. Glenn Smith
	Eugene Pitts	Albino Bismonte		E. T. Leonard	Richard G. Wilson
	E. J. Fesco	Richard Schmidt		F. H. Riordan	Keith Wrage
LA SALLE	Robert C. Kirkwood	Gilbert Miller	WOODFORD	Harry W. Darland	Joseph B. Perez
LAWRENCE	Donald Edwards	Donald Garcia	STUDENTS	Kazimieras Vaicius	Joe Phifer
LEE	Karl Deterding	Thomas Minogue	HOUSESTAFF	William Dunn	David Hopp
LIVINGSTON				Paul Stromborg	K. Thomas Papreck

## Chicago Medical Society

### *Delegates*

Ackley, William O.  
 Andelman, Samuel L.  
 Ashley, William F.  
 Bjornsson, Leif  
 Brislen, Andrew J.  
 Brown, Finley W., Jr.  
 Browns, Herschel L.  
 Budrys, Stanley  
 Burdick, Allison L., Sr.  
 Burdick, Allison L., Jr.

Burkhead, Howard C.  
 Chamberlain, Danford O.  
 Costanzo, Vincent A.  
 Cross, Roland R.  
 Des Rosiers, Raymond J.  
 Diffenbaugh, Willis G.  
 Dragisic, Branislav M.  
 Falloon, Edwin L.  
 Filipowicz, Roman I.  
 Fischer, Arthur R.

FitzGibbons, James P.  
 Flanagan, C. Larkin  
 Freda, Vincent C.  
 Friedheim, Jere  
 Friedell, Morris T.  
 Friefeld, Nathan  
 Gertz, George  
 Guerrero, Severo K., Jr.  
 Hamilton, Robert C.  
 Hamilton, Samuel  
 Harrod, John P., Jr.

Hesseltine, H. Close  
 Hinkamp, Joseph F.  
 Horton, Loren B.  
 Hrejsa, Allen C.  
 Hussey, Frank L., Sr.  
 Hutchison, William A.  
 Hyde, John S.  
 Jamieson, Rodney A.  
 Jensen, Harold L.  
 Jirka, Frank J., Jr.  
 Joslyn, A. Everett, Jr.

Kirschenbaum, M. Barry  
 Klinger, Alfred D.  
 Kobak, Mathew W.  
 Kozak, John A.  
 Kowal, Roland A.  
 Krol, Edward J.  
 Kunis, Arthur  
 Kwin, Frank C.  
 Lagorio, George L.  
 Lasky, Harold J.  
 Lobraico, Rocco V., Jr.

### *Alternate Delegates*

Banich, Francis E.  
 Banuchi, Fedor F.  
 Beblis, Ishoona  
 Beck, Charles A.  
 Burke, Edward A.  
 Byrne, Mitchel P.  
 Callaway, Lloyd, Jr.  
 Cermak, Miles  
 Chaljub, Najib  
 Christensen, Eldis M.

Ciskoski, Ronald J.  
 Clemis, Jack D.  
 Cohen, Meyer B.  
 Cohen, Gerald  
 Colbert, Maurice  
 Cunningham, Myles P.  
 De La Mata, Augustin  
 DeTrana, Frank A.  
 Farah, George S.  
 Ford, James W.

Frankel, Jerome J.  
 Froiland John L.  
 Gnade, Gerard R.  
 Goldstein, Henry A.  
 Gorecki, Joseph F.  
 Green, Martin W.  
 Greenfield, George  
 Gross, Alvin  
 Heller, Philip H.  
 Hemwall, Gustav A.  
 Hipskind, Myron M.

Housakos, George L.  
 Hudec, Ronald L.  
 Hussey, Frank L., Jr.  
 Jacobs, W. Francis  
 Johnson, Theodore  
 Juhasz, John C.  
 Kalsch, Harry E.  
 Kass, Harold M.  
 Kaz, Alex H.  
 Khan, Abdul Haye  
 Krolikowski, John R.

Lawrence, Arthur G.  
 MacNerland, Robert  
 McCabe, Mary Joan  
 Mella, Luis  
 Meyer, John E.  
 Muehrcke, Robert C.  
 Murray, Meredith B.  
 Nainis, William S.  
 Nayden, John  
 Nequin, Noel  
 Nowak, Frank J.

### *Delegates*

Lorance, L. M.  
 Lounsbury, B. Franklin  
 Lukaszewski, Edwin J.  
 Marcus, Anna A.  
 Markoutsas, George C.  
 Marshall, William  
 McCartney Charles P.  
 Mehlinger, Kermit T.  
 Meisenheimer, Martin P.  
 Moles, Joseph B.

Murphy, Daniel J.  
 Mustell, Robert R.  
 Nagel, Frank E.  
 Nemecek, Raymond W.  
 Neskodny, J. F.  
 Nicholas, Everett E.  
 Norberg, Clarence A.  
 O'Brien, James C.  
 Odell, Lester D.  
 O'Donnell, John W.

Palumbo, Carl F.  
 Patlak, Erwin M.  
 Paull, Murry M.  
 Petty, David T.  
 Quinlan, Donald  
 Razim, Edward A.  
 Reeder, Clifton L.  
 Rice, C. Malcolm, Jr.  
 Ruiz, Gonzalo  
 Saletta, Frank J.  
 Sarley, Vincent C.

Schlageter, Charles W.  
 Shapiro, Maynard I.  
 Smith, C. Otis  
 Soboroff, Burton J.  
 Sofield, Harold A.  
 Solon, Earl N.  
 Sperling, Richard L.  
 Suckow, Earl N.  
 Tansey, William J.  
 Thompson, J. Robert  
 Thomson, Andrew

Tope, John W.  
 Tovar, Jorge  
 Furner, George C.  
 Tworoger, Fred A.  
 Walkowiak, Lydia  
 Weigel, Charles J.  
 Weingarten, Charles  
 Williams, Jack  
 Wolkonsky, Peter  
 Yanez, Frank  
 Yatvin, Harold

### *Alternate Delegates*

Nyhus, Lloyd M.  
 Odiaga-Garcia, Ignacio  
 Okner, Henry B.  
 Olivieri, Ernest P.  
 O'Neil, Colman J.  
 Oselka, Adam  
 Pantone, Anton M.  
 Parisi, Frank  
 Paul, Jerome T.  
 Pedroso, Aldo F.

Peele, Bernard T.  
 Perritt, Richard A.  
 Pleotis, Peter  
 Pruc, Jeremias N.  
 Rowlette, Raymond S.  
 Rodriguez, Douglas D.  
 Rogers, B. H. Gerald  
 Saltiel, Isaac  
 Santilli, Dennis M.  
 Schifano, Joseph

Seed, Randolph W.  
 Shobris, Martin  
 Siedlinski, John E.  
 Sinaiko, Edward  
 Singh, Nerissa P.  
 Smith, William  
 Staley, Warren H.  
 Stromberg, William B., Jr.  
 Tatoes, Constantine J.  
 Ungar, Jacob  
 Urban, Conrad J.

Valadka, Bronius  
 Waller, Jesse E.  
 Yanong, Pio U.



**ILLINOIS STATE MEDICAL SOCIETY**  
**SCHEDULE OF MEETINGS**  
**INTERIM HOUSE OF DELEGATES**

**November 4-7, 1976**

**Continental Regency**  
**Peoria**

**Thursday, November 4, 1976**

7:00 p.m.	ISMS Publications Committee
7:00 p.m.	IFMC Board of Directors Meeting

**Friday, November 5, 1976**

7:30 a.m.	ISIME Board of Governors Meeting
9:00 a.m.	ISMS Board of Trustees Meeting
12:00 noon	ISMS Board of Trustees Luncheon
1:00 p.m.	ISMS Board of Trustees Meeting
5:30 p.m.	ISMS Board of Trustees Reception
6:15 p.m.	ISMS Board of Trustees Dinner
7:30 p.m.	ISMS Board of Trustees Meeting

**Saturday, November 6, 1976**

7:30 a.m.	ISMS Board of Trustees Breakfast
9:00 a.m.	House of Delegates Registration
10:00 a.m.	House of Delegates Meeting—Session I
11:30 a.m.	District Meetings
2:00 p.m.	Reference Committees Constitution & Bylaws Reference Committee B Reference Committee D
2:45 p.m.	Reference Committees Reference Committee A Reference Committee C
7:30 p.m.	AMA Delegation Meeting

**Sunday, November 7, 1976**

7:30 a.m.	ISMS Board of Trustees Breakfast
8:30 a.m.	House of Delegates Breakfast
9:00 a.m.	House of Delegates—Session II

# Committees of the House of Delegates

## COMMITTEE ON CREDENTIALS

Edward K. DuVivier, *Co-Chairman* (DS)

Charles W. Schlageter, *Co-Chairman* (CMS)

George Gertz (CMS)

Vincent C. Freda (CMS)

William C. Perkins (DS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

## COMMITTEE ON RULES & ORDER OF BUSINESS

Wayne Leimbach, *Chairman* (DS)

Vincent A. Costanzo (CMS) Edward G. Ference (DS)

E. J. Fesco (DS)

Charles J. Weigel (CMS)

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

## TELLERS AND SERGEANTS AT ARMS

Anna Marcus, *Chief Teller* (CMS)

William O. Ackley (CMS) Robert Barnes (DS)

Harry W. Darland (DS) Carl F. Palumbo (CMS)

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.



## REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

A. Everett Joslyn, *Chairman* (CMS)  
William B. Frymark (DS) Paul P. Lorenz (DS)  
Raymond W. Nemecek (CMS) Donald Quinlan (CMS)

*Standby:* Edward A. Razim (CMS)  
and August Rossetti (DS)

*STAFF:* Perry Smithers and Betty Kararo

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

## REFERENCE COMMITTEE A

Mack Hollowell, *Chairman* (DS)  
Samuel L. Andelman (CMS) James B. Campbell (DS)  
Mathew W. Kobak (CMS) Merle L. Otto (DS)

*Standby:* Murry M. Paull (CMS)  
and Eugene Pitts (DS)

*STAFF:* Jim Slawny, Ned Stuppy  
and Roseanne Christiansen

This committee shall consider and report to the House of Delegates its recommendations on the following:

Officers & Administration  
Finances  
Budgets and Publications  
Public Relations  
Membership and Miscellaneous

## REFERENCE COMMITTEE C

Don Hinderliter, *Chairman* (DS)  
Charles A. DeKovessey (DS) Joseph F. Hinkamp (CMS)  
Kermit T. Mehlinger (CMS) O. W. Pflasterer (DS)

*Standby:* Charles F. Eddingfield (DS)  
and Severo K. Guerrero (CMS)

*STAFF:* Dick Ott and Alice Underwood

This committee shall consider and submit its recommendations to the House of Delegates on the following subjects:

Education & Manpower  
Environmental, Community and Mental Health  
Social and Medical Services

## REFERENCE COMMITTEE B

Fred A. Tworoger, *Chairman* (CMS)  
Homer Fleisher (DS) H. Frank Holman (DS)  
C. Larkin Flanagan (CMS) Martin P. Meisenheimer (CMS)

*Standby:* Ernest F. Adams (DS)  
and William A. Hutchison (CMS)

*STAFF:* Al Lerner and Sylvia Fischer

This committee shall consider and submit its recommendations to the House of Delegates on subjects relating to:

Economics and Peer Review

## REFERENCE COMMITTEE D

Joseph B. Moles, *Chairman* (CMS)  
E. C. Bone (DS) Harold Kolb (DS)  
Robert C. Hamilton (CMS) Harold J. Lasky (CMS)

*Standby:* John P. Pope (DS)  
and Earl N. Suckow (CMS)

*STAFF:* Don Udstuen and Linda Forestor

This committee shall consider and report to the House of Delegates its recommendation on the following subjects:

Governmental Affairs  
Medical-Legal

# Resolutions

## Resolution 76N-1

Introduced by: George Lagorio, M.D.

Subject: State Medical Advisory Committee Problem

---

WHEREAS, The State Medical Advisory Committee of the Illinois Department of Public Aid has as its function to make effective recommendations to the Illinois Department of Public Aid; and

WHEREAS, In addition to the above, the Medical Advisory Committee of the Illinois Department of Public Aid has taken upon itself peer review functions of physician-provider under the Public Aid Medical System in the State of Illinois; and

WHEREAS, Multiple problems have arisen because of the retrospective audit being conducted by the Illinois Department of Public Aid on which some of these audits, members of the State Medical Advisory Committee are conducting peer review; and

WHEREAS, On numerous occasions, the Illinois Physicians Union has requested by letter and by telephone the opportunity to appear before the State Medical Advisory Committee to discuss problems that have arisen because of the retrospective audits; and

WHEREAS, Communication to this effect, was sent to the Chairman of the State Medical Advisory Committee on April 22, 1976, April 29, 1976, May 6, 1976, May 24, 1976, June 3, 1976, July 8, 1976 and July 22, 1976; and

WHEREAS, To date the only communication had with the Medical Advisory Committee to our request to appear before their Committee to discuss problems has been a refusal to allow us or other members of our organization who are rendering care to Public Aid recipients to appear; and

WHEREAS, The members of the Illinois Physicians' Union are also members of the Illinois State Medical Society in good standing; and

WHEREAS, It is one of the functions of the Illinois State Medical Society to judge the ethical behavior of its members; and

WHEREAS, All of the members of the Medical Advisory Committee are members of the Illinois State Medical Society in good standing; and

WHEREAS, There is strong suspicion and probability that the refusal of a physician or a group of physicians such as the Medical Advisory Committee of the Illinois Department of Public Aid to listen to legitimate complaints from other physicians constitutes a breach of medical ethics; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society authorize the establishment of an Ad Hoc Committee to investigate these charges levied by the Illinois Physicians Union against the Medical Advisory Committee of the Illinois Department of Public Aid; and be it further

RESOLVED, That the decision of this Ad Hoc Committee be reported to the next House of Delegates Meeting of the Illinois State Medical Society.

## Resolution 76N-2

Introduced by: Allan L. Goslin, M.D., for the Board of Trustees

Subject: Revised policy on Drugs, Prescriptions

---

WHEREAS, House of Delegates action calls for physician supervision of drug dispensing; and

WHEREAS, This action implies that the physician must supervise the pharmacist doing the dispensing rather than supervising the patient receiving the medication; therefore be it

RESOLVED, That the House of Delegates adopt the following revision in its existing policy on Drugs and Prescriptions:

"Public health departments should not conduct drug dispensing and distribution programs without direct medical supervision of patients receiving medication."

## Resolution 76N-3

Introduced by: Allan L. Goslin, M.D., for the Board of Trustees

Subject: Revised policy on Immunization Programs

---

WHEREAS, Existing policy states that "Illinois residents should be provided all types of immunization; and

WHEREAS, This policy is entirely too broad to be realistic; therefore be it

RESOLVED, That the House of Delegates adopt the following revision in its policy on immunization:

"Illinois residents should be provided access to all necessary or medically indicated immunization."

## Resolution 76N-4

Introduced by: George Lagorio, M.D.

Subject: Public Aid Publication

---

WHEREAS, The Public Aid situation in the State of Illinois has deteriorated into chaos; and

WHEREAS, The Illinois Physicians Union requested the leadership of the Illinois State Medical Society and the Chicago Medical Society to publish articles concerning this serious deteriorating situation in their respective publications; and

WHEREAS, The Illinois Physicians Union requested the opportunity to allow Dr. Carell Hutchinson, Dr. Finley Brown, Dr. George Lagorio and attorney, Mr. Roger Gold to write a series of articles which would consist of the following:

1. The deteriorating Public Aid situation in Illinois.
2. Problems within the Illinois Department of Public Aid itself.



3. Factoring companies.
4. How to prepare for medical audits by the Illinois Department of Public Aid.
5. Possible solution to the problem; and

WHEREAS, The above articles would be beneficial to all members of the Illinois State Medical Society; therefore be it

RESOLVED, That the House of Delegates instruct the leadership of the Illinois State Medical Society to allow the above articles to be published in the near future.

#### **Resolution 76N-5**

Introduced by: George Lagorio, M.D.

Subject: The Illinois Physicians Union Advertising Resolution

WHEREAS, On numerous occasions the Illinois Physicians Union has attempted to run advertisements in the Illinois State Medical Society Journal and in Chicago Medicine; and

WHEREAS, The advertisements, though always in good taste have been refused publication because of sponsorship by the Illinois Physicians Union; and

WHEREAS, These advertisements are of great importance to the practicing physician in the State of Illinois; and

WHEREAS, An example of one of the advertisements is as follows:

**Doctor**  
**Are You Having Problems With**  
**The Illinois Department of Public Aid?**  
**To Solve Your Problem**  
**Call**  
**Dr. George Lagorio**  
**NOW**  
**(313) 782-7281**  
**Room 350, 29 South LaSalle Street**  
**Chicago, Illinois 60603**

therefore be it

RESOLVED, That the Illinois State House of Delegates instruct its leadership to allow advertisements of the above type, even if they should include the words Illinois Physicians Union, to be run as a matter of informing the medical community of what is occurring, whether they be union members or not; and be it further

RESOLVED, That the Illinois State House of Delegates remind the leadership that the publications are to be used to educate and inform the membership on medical problems and that articles to this end should not be censored by the editorial board as long as the advertisements are in good taste.

#### **Resolution 76N-6**

Introduced by: George Lagorio, M.D.

Subject: Illinois Department of Public Aid Negotiating

WHEREAS, Since the last two House of Delegates Meetings which were held in Springfield and Chicago,

the Illinois Physicians Union has instituted the following program in regard to the Illinois Department of Public Aid as follows:

1. The Illinois Physicians Union has instituted a law suit in the United States District Court, charging that the fee structure established by the Illinois Department of Public Aid is in violation of Federal Regulations governing the amounts of money to be paid to providers for medical services under the Medicaid Program. Further, it alleges that the Illinois Department of Public Aid has violated numerous other Federal Regulations in its administration of the program. This law suit was brought against the Secretary of HEW, the Regional Director of HEW, the Illinois Department of Public Aid, and Mr. James Trainor, Director of that Department. In this law suit, the Illinois Physicians Union seeks to have the Federal Court order the Illinois Department of Public Aid comply with applicable Federal Regulations.
2. The Illinois Physicians Union has collected a vast amount of evidence regarding the corrupt practices of some of the factoring companies. This evidence has been presented to some of the governmental agencies and will be continued to be presented to the various governmental agencies as it is further developed.
3. The Illinois Physicians Union has developed procedures to be used by its members who provide medical services to Public Aid recipients who have been unable to collect bills submitted to the Illinois Department of Public Aid. These procedures will be designed to aid the provider of services in processing claims against the Illinois Department of Public Aid, which will include, if necessary, filing of suits against the Illinois Department of Public Aid in the Illinois Court of Claims.
4. The Illinois Physicians Union has developed procedures for assisting doctors who are being audited by the Illinois Department of Public Aid. Many aspects of these audits are unfair. The Illinois Physicians Union has assisted many physicians in challenging the results of these audits. The Illinois Physicians Union has made available to the members of the union its legal support when necessary. The Illinois Physicians Union will also make available to the member being audited the presence of a member of the Public Aid Grievance Committee at the time of the audit to insure that the audit is being carried out in an equitable fashion.
5. The Illinois Physicians Union has embarked upon a program of supporting political candidates who are aware of the problems faced by the medical providers in dealing with the Illinois Department of Public Aid and who are sympathetic to attempts to remedy these problems; and

WHEREAS, All of the above activities were being carried on by the Illinois Physicians Union in the last six months since the last House of Delegates meeting; and

WHEREAS, The Illinois Foundation for Medical Care was instructed by the House of Delegates at its last meeting to develop a program of negotiation with the Illinois Department of Public Aid to help physicians who render care to Public Aid recipients; and

WHEREAS, The only positive statement that can be made by the Illinois Foundation for Medical Care in

the last six months is that it has decided to collect information regarding the problem of physicians working with the Illinois Department of Public Aid so that it might further plan areas in which to become involved and those areas in which negotiations might be pertinent; and

WHEREAS, The above demonstrates clearly that the Illinois Foundation for Medical Care is not structured to function in this area in a meaningful and decisive manner, therefore be it

RESOLVED, That the House of Delegates instruct the leadership of the Illinois State Medical Society to use the Illinois Physicians Union as the vehicle to negotiate with the Illinois Department of Public Aid, and be it further

RESOLVED, That the House of Delegates instruct the Illinois Physicians Union to make a report at every meeting of the House of Delegates concerning progress in the various negotiations, and be it further

RESOLVED, That the Illinois Foundation for Medical Care be instructed to cease attempting to become the negotiating unit with the Illinois Department of Public Aid and continue to be, as it has up until now, the organization contracted with the Illinois Department of Public Aid to implement and operate the HASP (Hospital Admission Surveillance Program).

#### Resolution 76N-7

*Withdrawn*

#### Resolution 76N-8

Introduced by: George Lagorio, M.D.

Subject: Chicago Medical Society Advertising

WHEREAS, The Illinois Physicians Union supported for election as officers in the Chicago Medical Society the following slate in the last election:

President	Dr. Raymond J. DesRosiers
Secretary	Dr. Pablo Zalduendo
Chairman of the Council	Dr. Edward A. Burke
Vice-Chairman of the Council	Dr. Ignacio Odiaga-Garcia
Counselors-at-Large	Dr. Gonzalo Ruiz
	Dr. Vivencio Battung
	Dr. John Kozak
Alternate Counselors-at-Large	Dr. Finley Brown
	Dr. George T. Georgiou
	Dr. Lucius C. Earles III

and;

WHEREAS, The Editorial Advisory Board of Chicago Medicine refused to publish advertising concerning the Progressive Action Slate (see below); and

#### VOTE — SUPPORT — VOTE

##### The Progressive Action Slate

The Illinois Physicians Union supports the following candidates for election as officers in the Chicago Medical Society:

President-Elect	Dr. Raymond J. DesRosiers
Secretary	Dr. Pablo Zalduendo
Chairman of the Council	Dr. Edward A. Burke
Vice-Chairman of the Council	Dr. Ignacio Odiaga-Garcia
Counselors-at-Large	Dr. Gonzalo Ruiz
	Dr. Vivencio Battung
	Dr. John Kozak
Alternate Counselors-at-Large	Dr. Finley Brown
	Dr. George T. Georgiou
	Dr. Lucius C. Earles III

These physicians are ready to take decisive action to protect the rights of the practicing physician from hostile hospital administrators, unresponsive third party payers, insurance companies, and the abuses of the Illinois Department of Public Aid.

Vote for the Progressive Action Slate on  
Wednesday, June 9, 1976

WHEREAS, The Editorial Advisory Board is composed of the President, President-Elect, Chairman of the Board, Chairman of the Council, Vice-Chairman of the Council, Secretary and Treasurer of the Chicago Medical Society; and

WHEREAS, This raises a strong issue concerning a conflict of interest in the fair and equitable operation of the Chicago Medical Society and its publication, Chicago Medicine; therefore be it

RESOLVED, That the House of Delegates instruct its leadership to use whatever persuasion is necessary to facilitate the advertising for any opposition slate; and be it further

RESOLVED, That the Chicago Medical Society be requested to change the composition of the Editorial Advisory Board so as to obviate this obvious conflict of interest.

#### Resolution 76N-9

Introduced by: George Lagorio, M.D.

Subject: Censure

WHEREAS, The leadership of the Illinois State Medical Society failed to go along with the request for the Illinois Attorney General's office for help in polling the members of the Illinois State Medical Society on the factoring company issue; and



WHEREAS, The leadership of the Illinois State Medical Society failed to support the suit of the Illinois Physicians Union against the Department of HEW and the Illinois Department of Public Aid in any manner; and

WHEREAS, The Illinois State Medical Society has failed to help physicians being audited by the Illinois Department of Public Aid, even when they have asked for help; therefore be it

RESOLVED, That the House of Delegates censure the leadership of this assembly and recommend that the above areas are areas of proper involvement by the Medical Society; and be it further

RESOLVED, That the leadership of the Illinois State Medical Society in the future should become actively involved in these issues to the fullest for the better representation of the membership.

#### **Resolution 76N-10**

Introduced by: George Lagorio, M.D.

Subject: House Bill 2832—Licensing Factoring Companies

WHEREAS, House Bill 2832 which calls for licensing of medical factoring companies in the State of Illinois would have provided a financial bonanza to these factoring companies; and

WHEREAS, Even with Governor Walker's amendatory veto of September 22, 1975, if enacted would have placed Illinois in direct opposition to the Department of Health, Education and Welfare Regulations banning Medicaid payments to factors; and

WHEREAS, The Illinois State Medical Society took no steps to oppose the enactment of this Bill; and

WHEREAS, Only through the action of the Illinois Physicians Union, the Cook County Physicians Association, and the Phillipine Medical Association of Illinois was this Bill defeated; therefore be it

RESOLVED, That these organizations be commended for the work that they did in helping to defeat House Bill 2832 which appeared ready for passage unopposed; and be it further

RESOLVED, That in the future the Illinois State Medical Society take a more active step in opposing bills which would work to the detriment to the physicians in the State of Illinois.

#### **Resolution 76N-11**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Reconfirmation of Original Resolution

WHEREAS, The Illinois Foundation for Medical Care (IFMC) was charged with negotiating with third parties on behalf of physicians in amended Resolutions #74A-57 and 75N-11 and was funded to do so; and

WHEREAS, Illinois physicians who participate in Medicaid are under intense, unfair, and often illegal pressure from the Illinois Department of Public Aid (IDPA) and are often not provided with due process under the law; and

WHEREAS, Some leaders within organized medicine question the role of IFMC in supporting these physicians in their battles with IDPA and so have slowed IFMC's active entry into the administrative and legal resolution of these issues; and

WHEREAS, Time is of the essence; therefore be it

RESOLVED, That the House of Delegates reconfirm its original resolutions and request IFMC to proceed with all due speed in negotiating with the IDPA on behalf of Illinois physicians, recognizing that negotiation may require use of the court system and injunctive relief to obtain proper results.

#### **Resolution 76N-12**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Auditing of Physicians by Governmental Agencies

WHEREAS, The crisis in Medicaid continues with documentation of waste and fraud; and

WHEREAS, The great majority of Illinois physicians deliver high quality, ethical care within the program under considerable bureaucratic stress; and

WHEREAS, The leadership of organized medicine has proceeded cautiously in involving itself in defense of Illinois physicians for fear of defending corrupt physicians and thereby further eroding the image of medicine; and

WHEREAS, Many Illinois physicians are subject to ruthless and inaccurate audits, illegal search of confidential medical records, retroactive application of rules and regulations, and termination of payments while auditing continues on or before due process is completed; and

WHEREAS, The rules and regulations established by IDPA for Illinois physicians—if unchallenged—will become permanent and may spread to other national health programs thereby affecting the practice of all physicians—whether or not they participate in Medicaid; therefore be it

RESOLVED, That the House of Delegates directs ISMS leaders to immediately allocate resources to thoroughly investigate physicians asking for help who are undergoing audit and assist them in a vigorous defense using the full resources of ISMS, including legal support, and injunctive relief.

### **Resolution 76N-13**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Bureaucratic Harassment by Non-Peer, Unfair, Review

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WHEREAS, The Illinois Department of Public Aid (IDPA) has engaged in audit procedures of physicians' records using lay personnel; and

WHEREAS, The IDPA's findings are final with no recourse available outside the courts; and

WHEREAS, Illinois physicians welcome true peer review, but current IDPA policies violate this principle and have not changed despite all efforts and administrative review and negotiation; therefore be it

RESOLVED, That the House of Delegates direct the Board of Trustees and/or request the Illinois Foundation for Medical Care to seek immediate injunctive relief to halt this unreasonable, retrospective, unfair, "non-peer review."

### **Resolution 76N-14**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Cooperation on Costly Litigation

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WHEREAS, Illinois physicians are under siege in terms of unreasonable rules and regulations from third parties, especially the Illinois Department of Public Aid; and

WHEREAS, Legal battles to fight such onslaughts on the practice of medicine are quite expensive; and

WHEREAS, Some Illinois State Medical Society leaders have refused to support law suits which they agree with in principle, but which were filed by parties or organizations with which they disagree ideologically or conceptually; and

WHEREAS, Financial support in these law suits where common interest lies would be truly time efficient, cost-effective and not imply endorsement of the organization; therefore be it

RESOLVED, That the House of Delegates direct the Board of Trustees and/or request the Illinois Foundation for Medical Care to move strongly and fearlessly to support those legal battles in which it has interest and in which it would be cost-effective without fear of compromising its position, recognizing that this would, in no way, imply endorsement of the suing parties, their organizations or their other views.

### **Resolution 76N-15**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Incorporated Physicians in Medical Groups

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WHEREAS, Many Illinois physicians are incorporated and/or organized in group practices; and

WHEREAS, The Internal Revenue Service and other governmental agencies require that physicians and

corporations of physicians use their names appropriately and bill in the appropriate name of the corporation; and

WHEREAS, Many state and federal agencies including the Illinois Department of Child and Family Services and Medicare allow such billing in the corporate group name; and

WHEREAS, The Illinois Department of Public Aid has steadfastly refused to allow such billing in any but the individual physician's names; therefore be it

RESOLVED, That the House of Delegates repudiate this unreasonable position and direct the Board of Trustees and/or request the Illinois Foundation for Medical Care to seek immediate injunctive relief unless administrative negotiation is quickly productive to allow incorporated physicians groups to bill as corporations.

### **Resolution 76N-16**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Unacceptable Rules and Regulations

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WHEREAS, The Illinois Foundation for Medical Care (IFMC) staff has determined that the Handbook for Physicians issued January 1, 1976, by Illinois Department of Public Aid, was hastily put together by IDPA staff in response to HEW pressure; and

WHEREAS, The State Medical Advisory Committee to IDPA has confirmed that it did not review the handbook in toto, although initial drafts were reviewed and suggestions for corrections and changes made; and

WHEREAS, The Handbook for Physicians contains numerous odious, offensive, unfair and unreasonable regulations incompatible with the practice of high quality one-standard medical care; therefore be it

RESOLVED, That the House of Delegates repudiate the Handbook for Physicians in toto and direct ISMS leadership to work towards its removal as the body of rules and regulations controlling Illinois physicians, using whatever means necessary, including injunctive relief; and be it further

RESOLVED, That the ISMS offer its expertise to the IDPA in helping to formulate for the department a physician handbook which would ensure the delivery of high quality, one standard medical care to public aid recipients.

### **Resolution 76N-17**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Illegal Release of Medical Records

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WHEREAS, At the April, 1976, Annual Meeting of the Illinois State Medical Society, the House of Delegates passed amended Resolution 76A-47 requesting the Board of Trustees to empower a committee to "investigate fully the audit procedures of the Illinois Department of Public Aid (IDPA)"; and

WHEREAS, ISMS legal counsel issued a legal opinion in June, 1976, stating that medical records of Medicaid patients cannot be released without a written release from the patient for the date of service in question; and

WHEREAS, With any disagreement with audit findings by a physician, IDPA requires that physicians pro-



duce the medical records in question immediately without a written release from the patient; and

WHEREAS, Refusal to do so results in termination of payments and/or an immediate issue of a credit by IDPA against the account of the physician involved; and

WHEREAS, Compliance therefore results in serious ethical and legal questions and all discussions with IDPA on these issues have been fruitless and unproductive; therefore be it

RESOLVED, That the House of Delegates direct the Board of Trustees to have legal counsel seek immediate injunctive relief to prohibit IDPA from illegal seizure of medical records; and be it further

RESOLVED, That this questionable practice be made known to the welfare rights organizations in the State of Illinois so that they may also take action to assist Illinois physicians in protecting the constitutional rights of the welfare recipient.

#### **Resolution 76N-18**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Two Standards of Medical Care

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WHEREAS, The director of the Illinois Department of Public Aid (IDPA) has stated in writing that Medicaid funds are to be used to provide only episodic, intermediate limited care for patients holding green cards; and

WHEREAS, The IDPA has insisted that HMO programs funded by IDPA provide all inclusive care to the same recipients, including preventive health care, immunization, and out-reach programs; and

WHEREAS, This has fostered a dual standard of medical care incompatible with the principles of medicine and the oath of Hippocrates; therefore be it

RESOLVED, That the House of Delegates repudiate this concept of dual standard of care, so advise its members and direct the Board of Trustees and/or request the Illinois Foundation for Medical Care to ensure that all programs covering Medicaid patients provide the same high quality comprehensive care.

#### **Resolution 76N-19**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Economic Review of Medical Records

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WHEREAS, The Handbook for Physicians hastily and unilaterally issued January 1, 1976 by IDPA contains rules and regulations by which Illinois physicians who see Medicaid patients must abide; and

WHEREAS, The Handbook for Physicians states the length and breadth of the physician's note in the chart will be the sole factor in determining the type of work-up done and its compensation; and

WHEREAS, Principles and precedents once established are difficult to change and are likely to spread to all areas of medicine; and

WHEREAS, Emergencies, heavy patient volume, use of abbreviations, and other factors make this regulation ridiculous and unfair; and

WHEREAS, This regulation is easily circumvented should a physician wish to unethically, immorally and illegally write meaningless notes; therefore be it

RESOLVED, That the House of Delegates repudiate this section, so advise its members and direct the Board of Trustees and/or request the Illinois Foundation for Medical Care to take legal action if necessary to ensure the removal of this odious regulation.

#### **Resolution 76N-20**

Introduced by: Finley W. Brown, Jr., M.D.

Subject: Individual Physician Responsibility in Group Practice

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WHEREAS, The Handbook for Physicians hastily and unilaterally issued January 1, 1976, by the Illinois Department of Public Aid contains rules and regulations by which Illinois physicians who see Medicaid patients must abide; and

WHEREAS, The Handbook for Physicians states that in partnership or group practices where a physician sees a patient previously seen by another doctor in the group, and where the physician determines he must do a complete new history, review of systems and physical examination for whatever ethical reason, that physician may not bill for an initial examination since the patient may have only one initial examination under Medicaid regulations in the state of Illinois; and

WHEREAS, The physician is legally liable for his care and may be required to do such an examination medically, morally and ethically, and should be so compensated; and

WHEREAS, Principles and precedents once established are difficult to change and are likely to spread to all areas of medicine; therefore be it

RESOLVED, That the House of Delegates repudiate this regulation, so advise its members, and direct the Board of Trustees and/or request the Illinois Foundation for Medical Care to seek legal action if necessary to ensure its removal.

## **Weekend Workshop**

### **Introduction to CME Technique**

**An intensive weekend workshop *FOR* Hospital DME's and Program Chairmen,  
Medical Faculty, other CME Planners**

**October 29-31, 1976**

**Friday 7:00 P.M. to Sunday Noon**

**Oak Brook Hyatt House, Kent Room, Oak Brook, IL**

This workshop takes account of research findings that the most effective CME occurs in the clinical setting when colleagues teach and learn from one another. Accordingly, content is focused on:

Identification of learning needs as physicians perceive them  
Use of group problem-solving techniques

The workshop was offered successfully in 1974 and 1975 and has been modified on the basis of those two experiences. It will be of **special** importance this year to CME Planners in hospitals and specialty societies throughout the State as they gear up to help Illinois physicians satisfy the new Mandatory CME Law.

**For further details on program, schedule, and cost; write or call:**

**Illinois Council on Continuing Medical Education  
55 East Monroe Street Chicago, Illinois 60603  
Telephone: (312) 236-6110**

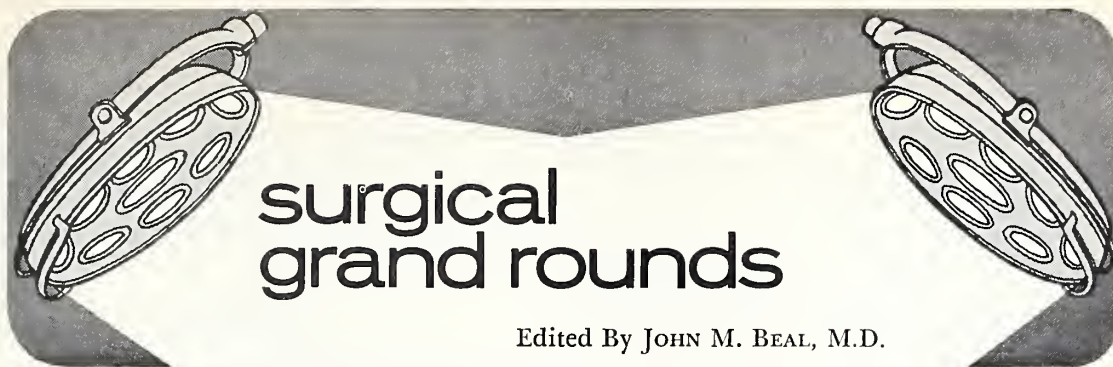
# **MARK YOUR CALENDAR**

## **ANNUAL MEETING OF THE ILLINOIS STATE MEDICAL SOCIETY**

**April 24 through 27, 1977**

This year's annual meeting will be held in Chicago's newest hotel in the SKY, the HOLIDAY INN-MART PLAZA, Orleans Street at the Merchandise Mart. Shopping, banking and many other facilities are accessible in the hotel. Free parking is provided for guests. The Holiday Inn-Mart Plaza has restaurants, show lounges, and an indoor swimming pool. Plan to bring the family to the ISMS Annual Meeting, and enjoy the many "extras" of the most complete RESORT hotel in Chicago.





*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Lakeside Veterans Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of December 16, 1975.*

## Achilles Tendon Rupture

**Dr. James Helgager:** A 35-year-old white man, whose vocation is teaching tennis and selling tennis equipment, was in good health until he injured his right foot. While playing in a squash doubles tournament, he experienced sudden pain in his right heel, ankle, and calf. He stated that he felt a sensation as if he had been struck with an object in the back of his calf, and at the same time he heard a loud sound which was audible to the other members playing in the tournament. He was disabled immediately and brought to the Emergency Room of the Northwestern Memorial Hospital.

### Background

His past history was essentially negative. A history of systemic illnesses, previous operation or long term medication was absent. Physical examination was unremarkable except for examination of the right lower extremity. There was diffuse tenderness and swelling of right foot and ankle and a palpable defect in the right Achilles tendon. The patient was unable to stand or push off with his right foot and there was a positive right Thompson's test. A diagnosis of ruptured Achilles tendon was made.

Laboratory studies including the blood count, urinalysis, survey-14, electrocardiogram, and chest X-ray were within normal limits.

Surgical treatment was selected and the Achilles tendon was approached through a posterior medial approach. The tendon was hemorrhagic, edematous, and macerated.

A criss-cross suture was utilized in the repair of the tendon. The plantaris tendon was used to reinforce the repair and to aid in the blood supply of the repair.

Following repair of the tendon, a long leg cast was applied. Because the gastrocnemius muscle originates from the femur and passes across the knee joint, the patient is placed in a long leg cast with the knee in a flexed position, which relaxes the Achilles tendon more effectively.

### Review of Literature

Rupture of the Achilles tendon is not a new entity and has been in the medical literature for many years. It was first described by Ambroise Pare in 1575. Although about 1/5 of all large tendon injuries involve the Achilles tendon, it is a commonly missed diagnosis. Lawrence and Kincaid in 1955 noted that of the 23 cases they had treated, 20% had been misdiagnosed as sprained ankle. This is not surprising because of the ecchymosis and lateral swelling of the ankle in both conditions.

This injury usually occurs in men over the age of 30, who engage in sports sporadically, particularly in the weekend squash or tennis player. It does not seem to occur very often in professional athletes. A healthy tendon is not likely to rupture, but injury occurs when stress is applied to a diseased or degenerated tendon. The sudden contraction of the calf muscle against resistance causes separation of the tendon in a degenerated area. Rupture of the tendon may occur when an individual is hit from behind with an object, falls from a height, or pushes off with the involved foot as in tennis and squash.

75% rupture through the body, 20% through the musculotendinous junction, and approximately 4% at the os calcis. These figures are interesting because in the laboratory, the normal Achilles tendon is able to withstand about 2000

lbs. of force before it ruptures and then it will rupture at either the musculotendinous junction or at the os calcis, not in the body.

Some underlying diseases predispose to rupture of the Achilles tendon, such as tuberculosis, syphilis, rheumatoid arthritis, gout, and long term steroid therapy. However, most patients do not have any of these underlying diseases and some authors now believe the principal factor is loss of blood supply. This is supported by radio-isotope studies on living tissues and amputated limb studies which have revealed a decreasing blood supply after the third decade. The blood supply is poorest in the area two to six cm. above the insertion of the Achilles tendon, the most common site of the tendon rupture.

### Diagnosis and Treatment

The diagnosis is made by the history of the sudden onset of pain in the calf, associated sometimes with the sensation of suffering a blow to the back of the calf. On physical examination, one notes a diffuse swelling and edema in the Achilles tendon region and the foot and ankle. There is loss of heel-toe gait, inability to stand on the toes of the affected foot, and a palpable defect in the Achilles tendon. The Thompson test was described by T. Campbell Thompson in 1955 and was reported in the *Journal of Trauma* in 1962. He found that this test was positive in all 50 patients that he had treated for Achilles tendon rupture in this series. In this test, pressure on the calf musculature fails to produce the normal plantar flexion of the foot, with the patient in the prone or kneeling position.

For years, the accepted treatment has been operative repair. There are certain complications of this method of treatment, which include skin slough, infection, adhesions, and sural nerve injury. Cast treatment has become popular during the last few years. The cast method of treatment involves treating the patient with a walking boot cast or a long leg cast in the gravity equinus position for eight weeks. After this 8-week period, the cast is removed and the patient is provided with a heel lift. He walks with a heel lift of approximately 2.5 cm for about four weeks. Exercises to strengthen his gastrocnemius muscle are performed and normal activity is gradually resumed.

Results with closed method of treatment are comparable to those obtained with open methods, and do not have the complications involved

with open methods of treatment.

We elected to treat this patient by operation because he made his living by playing tennis and his return to activity would be sooner by prompt surgical intervention.

### Misdiagnosis

**Dr. David Buchman:** I have very little to add to Dr. Helgager's presentation. The reason for this presentation is that Achilles tendon ruptures are too commonly misdiagnosed. In the past year, we have treated four patients for missed Achilles tendon ruptures. Delayed treatment is more difficult than primary treatment.

The history that these patients give is really quite diagnostic. Almost every one says he thought someone hit him. The key to making this diagnosis is first listening to the history; and second, looking at the patient. You must look both at the front and at the back of the ankle. The Achilles tendon is the major plantar flexor of the ankle. Sitting, you can substitute for it by using the posterior tibial, peroneal and toe flexor muscles. To make the diagnosis, have the patient lie prone on the table and look at the back of the ankle. If a tear is present, you can see and palpate a defect in the Achilles tendon. You were told what a Thompson test is; normally, if you squeeze the calf, the foot plantar flexes. If the Achilles tendon is ruptured, as you do that, nothing happens. That is diagnostic of an Achilles tendon rupture. It is important to think about and look for Achilles tendon rupture in patients with ankle injuries.

**Dr. John Beal:** Dr. Bachman, there are a number of weekend tennis players here. Is there something that one can do to prevent Achilles tendon injury?

**Dr. David Bachman:** In my opinion, there is nothing one can do to prevent it. Most people who have Achilles tendon ruptures have no premonition that it is going to happen. All tendons that rupture are abnormal. A normal tendon does not rupture. Some degenerative change takes place and there is no preventive procedure.

**Dr. Julius Conn:** About once a month we see a partial muscular tear misdiagnosed as phlebitis. Usually it occurs when the patient has gotten on or off a bus or stepped off a curb. It takes about five days for the hematoma to appear down to the ankle. So, a patient with sudden onset of pain and swelling in the calf area should not immediately be given heparin.

*(Continued on page 444)*



## National Health Insurance Definition



**NATIONAL:** affecting or involving a nation as a whole

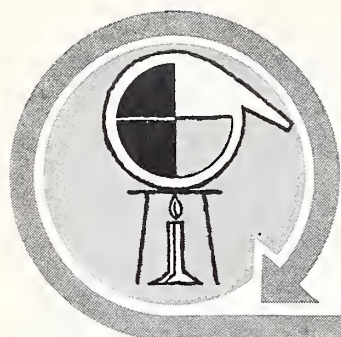
**HEALTH:** the state of being sound in body or mind

**INSURANCE:** a device for the elimination or reduction of an economic risk to all members of a large group and employing a system of *equitable* contributions out of which losses are paid

Assuming that it guarantees first rate care on an equitable basis, few of us would oppose this definition of national health insurance. However, the more than a dozen bills introduced since the 93rd Congress do not fit the above definition; nor does what is being sold to the public now as national health insurance guarantee first rate care. Of the three types of proposals, all unsatisfactory, the worst offers an insurance system financed and administered by the government. A look at our postal system, Medicare, Medicaid, and the Veteran's Administration Hospitals makes it clear that the government should not try to tackle the monumental task of administering a national health insurance program. However, we should not conclude that organized medicine should entirely reject the concept of national health insurance because some of the proposals are bad. It means, rather, that we should look objectively at all the plans, select what is good and reject that which is bad. We should really develop a plan that meets the definition without bankrupting the nation and robbing both doctors and patients of their rights.

*Joseph H. Skom, M.D.*

Joseph H. Skom, M.D.



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

The following new drugs have been marketed:

## NEW SINGLE DRUGS

**PEPTAVLON** G. I. Diagnostic Aid Rx  
Manufacturer: Ayerst Laboratories, Inc.  
Nonproprietary Name: Pentagastrin  
Indications: Evaluate gastric acid secretory function in an acidity, hypersecretion and determining adequacy of acid-reducing operations for peptic ulcer.

Precautions: Use with caution in pancreatic, hepatic, or biliary disease.  
Dosage: 6 mcg/kg s c  
Supplied: Ampules, ml/0.25 mg.

**TOLECTIN** Antiinflammatory Agent Rx  
Manufacturer: McNeil Laboratories, Inc.  
Nonproprietary Name: Tolmetin  
Indications: Relief of the signs and symptoms of rheumatoid arthritis.  
Contraindications: Do not give to patients in whom aspirin or other nonhormonal antiinflammatory agents produce asthma, rhinitis or urticaria.  
Dosage: Two tablets three times daily. Adjust to patient's response.  
Supplied: Tablets, 200 mg.

**VANCERIL** Antiasthmatic Rx  
Manufacturer: Schering Laboratories  
Nonproprietary Name: Beclomethasone dipropionate  
Indications: Chronic treatment with corticosteroids for control of symptoms of bronchial asthma.  
Contraindications: Status asthmaticus and other acute episodes of asthma.  
Administration: Two inhalations (100 mcg.) 3 to 4 times daily (Adults).  
Supplied: Inhaler, 10 mg.

## DUPLICATE SINGLE DRUGS

**CINO-49 Inj.** Glucocorticoid Rx  
Manufacturer: Tutag Pharmaceuticals, Inc.  
Nonproprietary Name: Triamcinolone diacetate  
Indications: Diseases responding to corticosteroid therapy.  
Contraindications: Systemic fungal infections.  
Dosage: Follow instructions in package insert.  
Supplied: Vials, 5 ml, ml/40 mg.

**DEZONE Inj.** Adrenocortical Steroid Rx  
Manufacturer: Tutag Pharmaceuticals, Inc.  
Nonproprietary Name: Dexamethasone sodium phosphate  
Indications: Diseases responding to corticosteroid therapy.  
Contraindications: Systemic fungal infections.  
Dosage: Follow instructions in package insert.  
Supplied: Vials, 5 ml, ml/4 mg.

**MICATIN Cream** Topical Fungicide Rx  
Manufacturer: Johnson & Johnson  
Nonproprietary Name: Miconazole nitrate  
Indications: Tinea pedis and related conditions  
Administration: Apply to cover affected areas twice daily.  
Supplied: Cream, 2%; tubes, 1 oz. and 15 Gm.

**MYCOQUIN 4.0** Dermatological Preparations Rx  
Manufacturer: Paul B. Elder Company  
Nonproprietary Name: Iodochlorhydroxyquin  
Indications: Dermatoses caused by bacteria and fungi.  
Contraindications: Tuberculosis, vaccinia, baricella or other viral skin conditions. Idiosyncrasy to iodine.  
Directions: Apply in small amounts to affected areas 3 or 4 times daily.  
Supplied: Tubes—Cream 3%.

**PAVAGRANT** Peripheral Vasodilator Rx  
Manufacturer: Amfre-Grant, Inc.  
Nonproprietary Name: Papaverine HCl  
Indications: Cerebral and peripheral ischemia with arterial spasm and myocardial ischemia complicated by arrhythmias.  
Caution: Patients with glaucoma.  
Dosage: One capsule every 12 hours; may be increased to one capsule every 8 hours.  
Supplied: Time-release capsules, 150 mg.



**PFIKLOR** Potassium Replacement Rx  
**PFIKLOR Powder**  
**PFIKLOR-F**  
 Manufacturer: Pfizer Laboratories  
 Nonproprietary Name: Potassium Chloride  
 Indications: Potassium replacement  
 Dosage: PFIKLOR: 15 ml diluted in water or fruit juice, 2 to 4 times daily.  
 PFIKLOR Powder: 1 packet (20 mEq.) in 4 ounces of water, 2 to 4 times daily.  
 PFIKLOR-F Effervescent Tablets: 1 tablet (20 mEq.) in 3 to 4 ounces of cold water, 2 to 4 times daily.  
 Administration after meals  
 Supplied: PFIKLOR—10% liquid, pints and gallons  
 PFIKLOR-F Effervescent Tablets  
 PFIKLOR Powder

**QUARZAN Caps** Antispasmodics Rx  
 Manufacturer: Roche Laboratories  
 Nonproprietary Name: Clindinium Bromide  
 Indications: Adjunctive therapy in peptic ulcer disease.  
 Contraindications: See package insert.  
 Dosage: 2.5-5 mg 3 or 4 times daily; adjust to response of patient.  
 Supplied: Capsules, 2.5 and 5 mg.

**THERALAX** Laxative o.t.c.  
 Manufacturer: Beecham Products  
 Nonproprietary Name: Bisacodyl  
 Indications: For relief of constipation.  
 Dosage: Adults: 2 to 3 tablets, 1 suppository.  
 Children: 1 to 2 tablets, 1 suppository.  
 Supplied: Tablets, 5 mg.  
 Suppositories, 10 mg.

**TRAMACIN Cream** Local Corticoid Rx  
 Manufacturer: Johnson & Johnson  
 Nonproprietary Name: Triamcinolone Acetonide  
 Indications: Corticosteroid-responsive dermatoses  
 Dosage: Apply to affected area b.i.d. to q.i.d.  
 Supplied: Tubes, 0.025%, 0.1%, 0.5%

#### COMBINATION PRODUCTS

**DUA-PRED Inj.** Corticoids Rx  
 Manufacturer: S. J. Tutag & Co.  
 Composition: Prednisolone acetate 80 mg/ml  
 Prednisolone Sod. Phosphate 20 mg/ml  
 Indications: Disorders responding to corticosteroid therapy.  
 Caution: See package insert.  
 Dosage: Individualized according to severity of the disease.  
 Supplied: Vials, 10 ml.

**OVCN** Progesterone-Estrogen Rx  
 Manufacturer: Mead Johnson Laboratories  
 Composition: Norethindrone 0.4 mg and 1 mg.  
 Ethinyl Estradiol 0.035 mg. and 0.050 mg.  
 Dosage: One tablet each for 21 days.  
 Supplied: Tablets

**PROXAGESIC COMPOUND-65** Nonnarcotic Analgesic Rx  
 Manufacturer: Tutag Pharmaceuticals, Inc.  
 Composition: Propoxyphene HCl 65 mg.  
 Aspirin 227 mg.  
 Phenacetin 162 mg.  
 Caffeine 32.4 mg.  
 Indications: Relief of mild to moderate pain.  
 Dosage: One capsule every four hours.  
 Supplied: Capsules

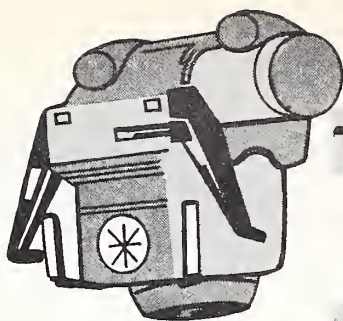
**RIMACTAZID** Antitubercular Rx  
 Manufacturer: CIBA Pharmaceutical Co.  
 Composition: Rifampin 300 mg.  
 Isoniazid 150 mg.  
 Caution: See package insert.  
 Dosage: Adults, 2 capsules once daily; 1 hour before or 2 hours after meals.  
 Supplied: Capsules

#### NEW DOSAGE FORMS

**DIPROSONE Ointment** Local Corticosteroid Rx  
 Manufacturer: Schering Laboratories  
 Nonproprietary Name: Betamethasone Dipropionate  
 Indications: Corticosteroid responding dermatoses.  
 Administration: Apply to affected area twice daily.  
 Supplied: Tubes, 15 and 45 gm.; Ointment, 0.05%

**SOMOPHYLLIN Liquid** Bronchodilator Rx  
 Manufacturer: Fisons Corporation  
 Nonproprietary Name: Aminophylline  
 Indications: Symptomatic relief of asthma.  
 Dosage: Adults—4 or 5 tsp.  
 Children—over 4 years old; initial 1 tsp. per 40 lbs.  
 Supplied: Bottles, 8 ozs, 105 mg/5 ml

**TUSSCAPINE Tablets** Cough Preparation o.t.c.  
 Manufacturer: Fisons Corporation  
 Nonproprietary Name: Noscapiene  
 Indications: Temporary control of cough  
 Dosage: Adults—1 to 2 tablets 4 to 6 hrs. apart, not to exceed 8 tablets p. day.  
 Children—6 to 12 yrs—1 tablet t.i.d. or q.i.d.  
 Supplied: Chewable tablets, 15 mg



## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

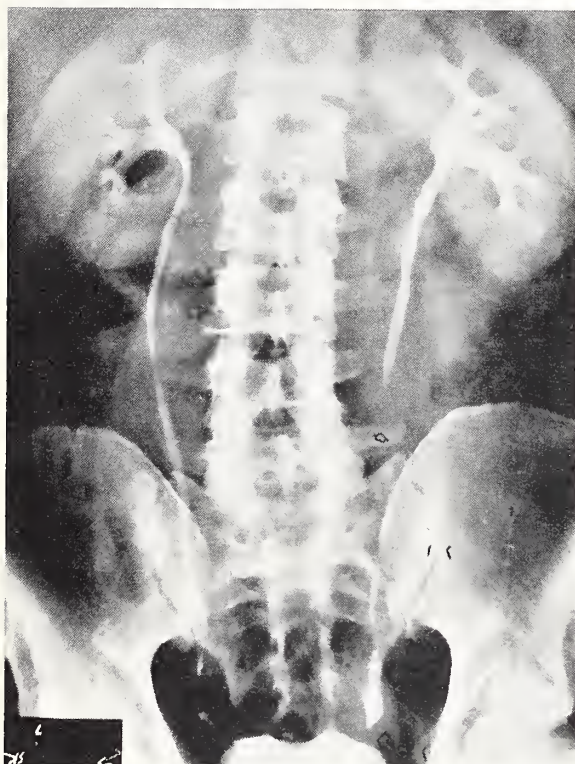


Figure 1

This is a 28-year-old football player who two years prior to this admission had been hospitalized and in traction for 6 weeks for a so-called slipped disc. Following this the patient began to drain pus through a fistulous tract in his left mid-back. (Figures 1, 2 and 3)

**What's your diagnosis?**

*(Answers on page 444)*

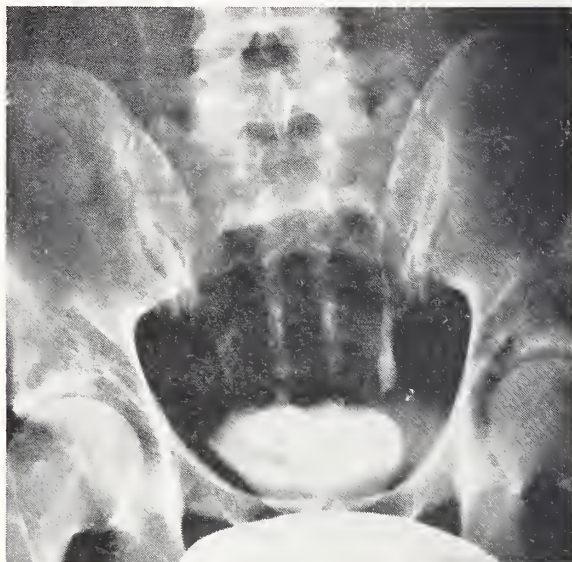


Figure 2



Figure 3





## membership forum

Dear Dr. Skom:

I have long been wanting to write about a problem concerning the cost of medical care. When I ran the Epilepsy Clinic, I was impressed with the "shopping" of many patients who went from clinic to clinic getting expensive workups. But this caused duplications of medical evaluations, which were quite costly, and no effective treatment. I advocated at one time, in a publication, that patients with a certain disease, like epilepsy, should be registered so steps might be taken to prevent this.

After many similar experiences with Medicaid, I have decided not to consult any more patients on Medicaid, unless they were referred by another physician. I have seen many patients on Medicaid who have no managing physician. They go from one doctor to another. There is no way of controlling their activity and there is no way of giving them good medical care. When this has happened, I have had no recourse. Also, I have never received payment for my services.

Now a similar problem is developing in industrial compensation cases. A patient no longer has to go to a doctor designated by his employer or insurance company. Illinois state law has given him free choice. I realize, as physicians, we had to advocate free choice. Unfortunately, when the cost is no burden to the patient, he does not always use good judgment. I have reviewed medical-legal files in which there have been multiple physicians. Yet, no one has taken care of the patient. It seems the only reason for going to many physicians is to increase the medical cost so perhaps there will be a larger settlement fee. I do not feel that a patient always has the judgment to select a consulting physician. Certainly he should have a managing physician to designate whatever consultation is necessary and to manage the patient. I feel this criticism is very important. The Medical Society should review this situation in some fashion.

Sincerely,  
Alex J. Arieff, M.D.

---

## ILLINOIS PSYCHIATRIC SOCIETY THIRD ANNUAL FALL WEEKEND MEETING

NOVEMBER 5-7, 1976

O'HARE MARRIOTT, CHICAGO

The three-day meeting, focusing on "New Issues in Accountability of Psychiatric Practice," will feature seminars and workshops on peer review, treatment of manic depressive illness, female sexual dysfunctions, certification, malpractice and other matters of interest to Illinois psychiatrists. Robert Gibson, M.D., President, American Psychiatric Association will be the keynote speaker at the November 6 banquet. Category I CME credit will be available.

For registration forms, please contact W. J. Smith, Illinois Psychiatric Society, 55 East Monroe, Suite 3510, Chicago 60603 (312/782-1654).



#### RECENT CHANGES

**federal register**

**Providing  
Drug Information  
to Physicians**

**Informational  
Bulletin #433-76**

**National  
Health  
Insurance**

**special report**  
**Malpractice  
insurance:**

**drug  
bulletin**

**Health care doesn't  
need more red tape**

**Drug firms challenge  
'MAC' rules**

**Drug  
Substitution**

**RESEARCH**

**Mailgram**



# THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

**Drug substitution** In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it does not enforce the same standards for hundreds of "follow-on" products that it had applied to the original FDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

**MAC** Maximum Allowable Cost, MAC for short, is a federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

**The drug lag** The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005

## **Abstracts of Board Actions**

*(Continued from page 270)*

### **Designation of Primary Care Specialties**

The Board denied a request from the Illinois Society of Internal Medicine to endorse a resolution recognizing only family practice, internal medicine, pediatrics and obstetrics/gynecology as primary care specialties. It was pointed out that the AMA House of Delegates recently rejected a report containing a similar designation and the issue should be resolved at the national level, rather than the state.

### **HSA Region #9**

ISMS provided a letter of endorsement to Region Nine Health Systems Agency, Inc., which the agency will submit with its application for designation. The HSA was developed with assistance of the Will-Grundy and Kankakee County Medical Societies.

### **Doctor's Job Fair**

The 1976 Doctor's Job Fair will be held Sunday, December 5, at the Sheraton Oakbrook Hotel, Oakbrook, Ill. Communities needing physicians—and doctors looking for a place to practice—are urged to attend the fair. Registration is handled by the Physician Recruitment Program at ISMS headquarters.

### **Office Space Requirements**

Anticipating the need for additional office space, ISMS will rent an additional 4,500 square feet of space at 55 E. Monroe St. Allocation of the space will be made according to the respective needs of ISMS, Illinois Foundation for Medical Care, Illinois Council on Continuing Medical Education and the Illinois Medical Insurance Services, Inc.

### **Revised Budget Approved**

The Board approved a revised 1976 budget which reflects:

(A) A \$35,370 decrease in anticipated expenditures of Insurance Administration which was phased out with the implementation of the Exchange; (B) A new \$68,279 item to fund the new sub-division of Computer Services (partially offset by anticipated billing income of \$40,000); (C) Increased annual meeting expense due to an \$11,750 cost for holding an interim session of the House of Delegates; and (D) A \$9,802 increase in anticipated meeting and travel expenses for the Board of Trustees. Anticipated revenue will cover all but \$3,455 of the revised expenditures.

### **Intern/Resident and Student Business Sessions**

The Committee on Constitution and Bylaws was directed to prepare appropriate amendments to ISMS bylaws that would establish a Resident Physicians Section and a Student Business Session. In a related action, the Board reviewed proposed bylaws for both groups and directed that they be forwarded to the House of Delegates for approval.

### **Illinois Medical Journal**

Dr. Theodore R. Van Dellen, who has served as editor of the Illinois Medical Journal for many years, will retire January 1, 1977. A replacement is being sought. IMJ advertising rates for next year will remain the same as 1976 pending review of the 1977 first quarter experience.

### **Policy Manual**

The Board approved for publication in the 1976 Policy Manual statements on the following subjects:



Electromyoneurographic Procedures and Examinations; Drugs-Prescriptions; Immunization Programs; Eyes; Marijuana; Prolonging Human Life; Hospital-Medical Staff-Management Relationship; Confidentiality; Government Health Insurance Programs; Legal Definition of Death; Opinion Polls; Election of AMA Delegates; ISMS Candidates for AMA Positions, and Professional Liability.

The Policy Committee will introduce resolutions to clarify existing policy statements on Drugs-Prescriptions, Immunization Programs, and Opinion Polls.

### **Registration and Education**

ISMS received a letter from Ronald Stackler, Director of the Department of Registration and Education, acknowledging that it is not necessary for physicians to answer questions about malpractice suits on the current registration form for controlled substances. In its response to Stackler, ISMS will point out that HB 3957 mandates reporting of malpractice claims to the Insurance Department, not R & E.

Because the Department was late in sending out physicians' registration renewal applications this year, ISMS will request the department to extend for 30 days the deadline for filing renewal applications.

### **Anti-Substitution**

Anticipating further legislative efforts to allow pharmacists to substitute drugs, the Board reiterated its opposition to repeal of anti-substitution laws. It also urged incorporation of educational materials relating to generic prescribing in the IMJ, with the suggestion that generic prescribing be acceptable only if based on individual patient needs including positive selection of pharmaceuticals by physicians.

### **Conferences on School Health, Nutrition and Geriatrics**

ISMS will co-sponsor the 19th Annual Conference on Nutrition in Medicine and the Conference on School Health. Dates and locations have not yet been determined.

The Committee on Aging was authorized to develop a clinical program on geriatrics for primary care physicians, residents and students. A one or two-day program is planned for next spring.

### **Role of Pharmacist in Hypertension Screening**

While acknowledging that ISMS policy recognizes multiphasic health testing as a fact-finding system and could include blood pressure screening by pharmacists, the Board stated that monitoring drug regimens and commenting on the effectiveness of various drug therapies constitutes the practice of medicine and is beyond the purview of pharmacists. The action followed a request from the Chicago Heart Association for an ISMS position statement on the pharmacist's role in hypertension screening. The ISMS delegation to the AMA will be asked to develop an appropriate resolution on the subject for consideration by the AMA House of Delegates.

### **Head and Neck X-Radiation**

The ISMS-IHA Joint Committee on Thyroid Neoplasms Associated with Head and Neck X-Radiation reported that it: (1) Conducted a statewide public education campaign; (2) Formulated guidelines to assist hospitals in establishing screening programs; and (3) Developed suggested treatment guidelines which were distributed to all Illinois physicians. The Board agreed to call attention to a National Cancer Institute report-parallelizing those guidelines-through the IMJ. The Committee was then discharged at its request.

## Legislation

ISMS will:

1. Oppose HB 3124, which would set up a state-operated, health-provider-managed Patient Compensation Fund, unless cost savings and other amendments satisfactory to ISMS are added.
2. Continue to oppose legislation to license hypnotists or their assistants.
3. Seek reintroduction of a family practice residency bill, which would set up a statewide council on family practice residency programs authorized to subsidize such programs with state funds.
4. Seek reintroduction of a bill to create a statewide nutrition council to study the nutritional problems of school children.
5. Seek legislation which would provide permanent exemption from liability for blood and blood products.
6. Support reintroduction of HB 3513, which would restrict the practice of acupuncture and similar procedures to physicians licensed to practice medicine in all its branches.
7. Continue to oppose any legislation to define death, but if a legislative definition is inevitable, the following terminology will be considered acceptable:
  - (A) Death of a person will be deemed to have occurred if, based upon usual and reasonable standards of medical practice, it is determined that such person has experienced the permanent and irreversible cessation of the spontaneous integrated functioning of the respiratory, circulatory and nervous systems;
  - (B) The determination referred to in (A) shall be made, and death pronounced, by a physician licensed to practice medicine in all its branches who is in charge of the person's care, or in the absence of medical attendance, the coroner or a medical examiner;
  - (C) Death will have occurred at the time of cessation of the relevant functions referred to in (A).

## Confidentiality

The Board requested that the Medical Legal Council develop a possible position on ownership of medical records, so that ISMS can adopt a formal policy to guide members. The Task Force Committee on Moves to Counter-litigation also will consider this as it relates to professional liability.

## Prudential, Aetna Reimbursement Procedures

The Board directed the Council on Economics and Peer Review to: (1) Study Prudential Insurance Company's reimbursement practices and develop recommendations for ISMS policy; (2) Consider the propriety of referring to the Federal Trade Commission Prudential's request that physicians accept its reimbursement amount in full satisfaction of the physician's charge; and (3) Develop a resolution expressing ISMS objection to the concept of an insurance company telling physicians how to practice medicine, which Aetna Life & Casualty did recently by suggesting that a physician use alternative surgical procedures. ◀

## An Ounce of Postage Can Cost You Pennies

*Nation's Business*, monthly magazine of the Chamber of Commerce of the United States, recently passed along some tips on how to save postage costs from the National Consumer Finance Association. One tip: Check your postal scale often. A quick way is to put five quarters on it. They should weigh just under an ounce. Don't overwrap. Every foot of paper tape weighs about an eighth of an ounce.



# Phosphohexose Isomerase:

## A Useful Parameter in the Management of Neoplasia

BY DENNIS R. SAMUELSON, M.D./MACOMB

*The utility of a simple serum glycolytic enzyme determination in the evaluation of neoplasia is presented. Improved methodology and satisfactory sensitivity encourage additional investigation.*

Phosphohexose isomerase (PHI) is a glycolytic enzyme which has been reported to become significantly elevated in neoplastic cell lines and the sera of patients with cancer. Although LDH and its isoenzymes, acid phosphatase, adolase and others have been useful in determining the presence and extent of metastatic disease, PHI has been shown to be elevated in a greater percentage of patients with several epithelial cancers and metastatic liver disease than other serum enzymes.<sup>1</sup>

A rapid ultraviolet procedure for PHI assay based on the method of Beuding and MacKinnon<sup>2</sup> (Worthington Biochemical Corporation, Freehold, New Jersey) exhibits improved sensitivity over the Bodansky technique<sup>3</sup> and should encourage further investigations of this enzyme as a tool in the evaluation of patients with occult neoplasms as well as the management of cancer therapy. Prompted by reports by Griffith and Beck<sup>4</sup> and Ratliff the following study was undertaken to assess the utility of PHI in establishing a diagnosis in equivocal cases of cancer and in ascertaining the extent of dissemination in patients with proven cancer.

### Methods and Materials

One hundred and twenty hospitalized adult patients with varying degrees of clinical suspicion of malignancy were studied. The mean age of the study population was 64 and the group was comprised of 81 females and 39 males. Fasting serum specimens were assayed by the rapid UV method of Beuding and MacKinnon. This technique is based upon the utilization of the substrate fructose-6-phosphate coupled to the indi-

cator enzyme glucose-6-phosphate dehydrogenase resulting in the generation of reduced NADH. The resulting increase in absorbance at 340 nm. is used as the measure of serum PHI activity. Instrumentation consisted of a Gilford 300-N spectrophotometer in absorbance mode and equipped with a flow-through thermocuvette (model 3017) and data lister (model 4006) in timed position. The assay was performed at 30°C. and reported as International Units/liter at 30°C. The normal range employed was 20-90 I.U./L.<sup>5</sup> All serum samples were separated within thirty minutes of collection and assayed within six hours of collection. Hemolyzed samples were rejected. The method was modified by 50% sample and reagent volume reduction resulting in the use of only 0.05 ml. of sample. The reaction time was approximately three minutes.

Accumulated assays on pooled serum controls yielded a coefficient of variation approximating 6%, similar to that reported by Ratliff.

### Results

A total of forty patients (33%) had elevated serum PHI levels and of these 27 were proven to have cancer for a predictive value of 67.5% (see Table 1). The remaining thirteen (32.5%) were considered false positive elevations. A breakdown of the clinical diagnoses in those patients with noncancerous elevations is shown in Table 2. Others have shown that hepatocellular injury, hemolysis, transfusion, and major surgery can be associated with elevations of serum PHI activity. In this series ten patients appeared to have varying degrees of hepatocellular injury.

A previous report<sup>4</sup> has demonstrated 80% of patients with metastatic breast carcinoma to have elevated serum PHI levels. This is greater sensitivity than reported with all other glycolytic and oxidative enzymes. Of the total number of patients in this series with proven malignancy (38), 27 (71.1%) were elevated and 25 of 32 (78.1%) with metastatic malignancy had positive PHI's (see Table 3). The range of positive PHI values was from 90 to 1012 I.U./L. with the highest levels being observed in those patients with hepatic metastases. The secondarily

DENNIS RAY SAMUELSON, M.D., is a clinical and anatomic pathologist. He is Director of Laboratories and Nuclear Medicine at McDonough District Hospital, Macomb. Dr. Samuelson is also President of the McDonough County Medical Society.



**Table 1**  
**27 Patients with Malignancy and Elevated Serum Phosphohexose Isomerase**

A.	Bronchogenic carcinoma	7
B.	Adenocarcinoma, colon	6
C.	Adenocarcinoma, breast	3
D.	Transitional cell carcinoma, bladder	2
E.	Malignant lymphoma	2
F.	Renal cell carcinoma	1
G.	Granulosa cell carcinoma, ovary	1
H.	Undifferentiated carcinoma, thyroid	1
I.	Adenocarcinoma, pancreas	1
J.	Squamous cell carcinoma, tonsil	1
K.	Adenocarcinoma, primary site undetermined	1
L.	Chronic granulocytic leukemia	1

*All of the above patients exhibited evidence of metastases with the exception of one patient with adenoid cystic carcinoma of the breast and one patient with adenocarcinoma of the rectum.*

**Table 2**  
**13 Patients with Elevated Serum Phosphohexose Isomerase and no Evidence of Malignancy ("False Positive" PHI'S)**

Diagnosis	Number	PHI (IU/L.)
Acute viral hepatitis	1	108
Acute cholecystitis (one with choledocholithiasis and obstruction)	2	263 482
Laennec's cirrhosis with fatty metamorphosis	1	105
Dehydration and fatty metamorphosis, liver	1	344
Miliary tuberculosis	1	129
"Flu syndrome"	1	93
Post-operative TUR	1	103
Acute myocardial infarction, post countershock	1	128
Transient cerebral ischemic episode (TIA)	1	93
Acute pancreatitis	1	106
Somatic trauma with hemorrhage and hematomata	1	125
Cholestatic hepatic disease, etiology undetermined	1	268

involved organs are listed in decreasing frequency in Table 4 with the mean levels for the two most often involved organs, liver and lymph nodes. The highest levels of PHI were noted in those patients with rapid clinical deterioration and there appeared to be a crude correlation between degree of elevation and the estimated tumor volume in six celiotomized and/or autopsied patients.

### Summary

Although the study was limited the improved sensitivity and ease of performance of available methodology along with the illustrated yield indicate that further evaluations are certainly

**Table 3**  
**Total Number of Patients with Malignancy Studied—38**

Category	Number	Per Cent
A. Patients with positive PHI with malignancy	27	71.1%
1. Patients with positive PHI with localized malignancy	2	5.3%
2. Patients with positive PHI with metastatic malignancy	25	65.8%
B. Patients with "false" negative PHI's (those with malignancy)	11	28.9%
<b>Total</b>	<b>38</b>	

*78.1% of those patients with metastatic malignancy had elevated serum PHI activity as opposed to approximately 33% of those with localized disease.*

**Table 4**  
**Organs Involved by Metastatic Malignancy and Mean Serum PHI Levels for the Two most Frequently Involved**

Organ	Number	Mean PHI
liver	9	325 IU/L.
lymph nodes	8	215 IU/L.
presumptive lymph nodes	3	—
brain	2	—
lung	1	—
bone	1	—
vein invasion	1	—
<b>Total</b>	<b>25</b>	

warranted. However, the fairly low predictive value and incidence of false negativity would appear to compromise any application as a solitary screening tool. As with other neoplasia monitoring parameters such as CEA and alphafetoprotein, negative results may be misleading and should not lead to a false sense of security. The fallacy of compromising an evaluation in the patient clinically suspected of harboring a neoplasm, based upon a negative PHI result, must be recognized.

Serum PHI may also be of great value in assessing the extent of neoplastic disease and in individualizing therapy and monitoring efficacy. ◀

### References

1. Ratliff, C. R.: "Serum Phosphohexose Isomerase: A glycolytic enzyme for appraising neoplasia." Section of Biochemistry, Scott and White Hospital Foundation, Temple, Texas. A narrative presentation at the Annual Southern California Laboratory Conference, March 6-7, 1973, Anaheim, California.
2. Bueding, E., and MacKinnon, J. A.: *J. Biol. Chem.*, 215:507, 1955.
3. Bodansky, O.: *Cancer*, 7:1191-1199, 1954.
4. Griffith, M. M., and Beck, J. C.: *Cancer*, 16:1032-1041, 1963.
5. Schwartz, M. K.: *Clin. Chem.*, 19:10, 1973.



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## CME Congress

(Continued from page 289)

### III. Broker

The compilation of on-going and future scheduled CME programs in our CME Calendar is an attempt to inform our clients of what is currently available. Our accreditation program, supplementing that of the AMA, is designed to assure the client that each program will meet quality standards.

There is a broad gap, however, in our “broker” function, because many educational needs of our clients are not being adequately fulfilled. We must either seek more providers of such educational material or stimulate the current providers into multiplying and diversifying their programs to meet these needs. Being a catalyst is not enough—a strong stimulation is necessary. Our many medical schools are the obvious providers referred to above, and they are now moving to meet the needs of our clients, formulating educational programs and methods to meet these needs.

The Third Annual Congress made the provider problem a major issue—with extensive active participation by representatives from the medical schools.

Periodic re-appraisal of CME programs is built into our accreditation mechanism. Insistence on evaluation of the results of CME programs by on-going assessment is an essential for re-accreditation. The Fourth Congress placed special emphasis on medical care evaluation and its impact on CME.

ICCME can and should facilitate the mechanism whereby our client's assets—his professional skills—continue to appreciate in value, are insured by periodic refreshing, and are passed on to his beneficiaries, his patients. Our client, who is paying for our services, should not be satisfied until all his educational needs—many of which he was unaware of prior to our entrance upon the scene—are fully provided for.

Robert T. Fox, M.D.

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### Surgical Grand Rounds

(Continued from page 428)

**Dr. David Bachman:** That is correct. A very common injury is a partial tear of the medial part of the gastrocnemius at the musculotendinous junction. This may also be misdiagnosed as a plantaris tear. I have never seen a ruptured plantaris, even with a completely ruptured Achilles tendon. I think that entity does not exist. ◀

## Viewbox

(Continued from page 434)

**DIAGNOSIS:** *Retroperitoneal Abscess with Fibrosis*—Figure 1 demonstrates a slight lateral deviation of the left kidney with a mild hydro-ureter of the upper half. This is an area of erosion at the site of the superior aspect of the left fifth lumbar transverse process. There also appears to be an increase in the bony density of the left pedicles of the lumbar spine. In addition a constant area of narrowing is noted at the distal ureteral vesicle junction on the left side. Following an injection of a sinus tract an irregular fistulous communication was noted extending down to the upper portion of the bony pelvis. Following a prolonged surgical procedure all the identifiable tracts were evacuated and the involved ureter was freed up, and the transverse process was partially resected. This represents an extremely unusual retroperitoneal infection which seems to involve all the muscle planes and extends on to bone resulting in chronic osteomyelitis and apparently resulted from a chronic Staphylococcus. ◀

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### EKG (Continued from page 447)

#### ANSWERS: 1. A,B 2. E

The ECG demonstrates the Q wave and ST wave changes of an evolving or recent inferior wall myocardial infarction. There is also Q-T interval prolongation to 0.44 seconds best seen in leads I, III, avL, V<sub>5</sub> and V<sub>6</sub>. The Q-T interval is measured from the Q wave or the onset of the R wave to the end of the T wave and should be measured in the leads where it is longest. In addition to the conditions listed in question 2, the Q-T interval will vary with the heart rate, age, and sex. There are tables available to check Q-T intervals. In this case at a rate of 83 beats per minute, 0.44 seconds is too long. Formulas also have been devised to correct the Q-T interval for heart rate. One of these is

$$Q-T_{\text{calc.}} = \frac{Q-T \text{ measured second}}{R-R \text{ cycle second}}$$

One simple way is to assume any Q-T interval that is greater than half of the R-R cycle is too long. By any of these criteria, the Q-T interval here is prolonged.

This prolongation of the Q-T interval was blamed on quinidine. However, this is not regarded as evidence of toxicity. Quinidine toxicity would be assumed when the QRS widened by 25% or more. The medication was continued, and the patient was subsequently discharged from the hospital. ◀



# Government by the Minority

Recent publications have cited polls ranking the medical profession among the professions most respected by the public. At the bottom were politicians—Congress and legislators, the government.

Medicaid scandals, no funds for Social Security, delay in implementing A-New Jersey immunization programs, Medicare mishaps, government boondoggles—what's going on? Perhaps, just perhaps, it's becoming patently obvious that the government can not assume the role of health care deliverer. Perhaps, also, over regulation is coming to be recognized as an impedence to health care. Perhaps people, the public, are beginning to feel the crunch of ever higher taxes for fewer government-supplied services. While you don't get anything for nothing, under government health plans the public may get little for a lot.

How has this all come to be? Are our senators and representatives immune to reason and objective judgment? Not necessarily. But the orientation of some might need modification. Maybe certain legislators should be replaced, especially those causing government to be the least re-

spected profession, according to public opinion polls.

In addition, if programs contrary to one's interest or contrary to good health or good health care delivery are being developed and espoused by the legislators, keep in mind that they were probably elected by a minority.


Recent statistics indicate that in a good election, perhaps 70% of the registered voters participate. It only takes a plurality, not a majority of those actually voting, which is a lot fewer than those eligible to vote, to elect a candidate. Think about this!

If you don't like programs being proffered by the government, if you don't agree with positions of particular legislators, if you feel put upon, you *can* do something about it.

Get active—support the political candidate you feel would best represent the needs of the public. Talk to your patients, encourage them to vote. Write your legislators, sharing your concerns and viewpoints.

Minority government in and of itself doesn't make it bad. But if things must be changed, throw the rascals out—elect better people.

RO



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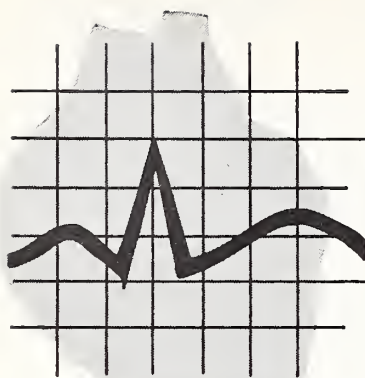
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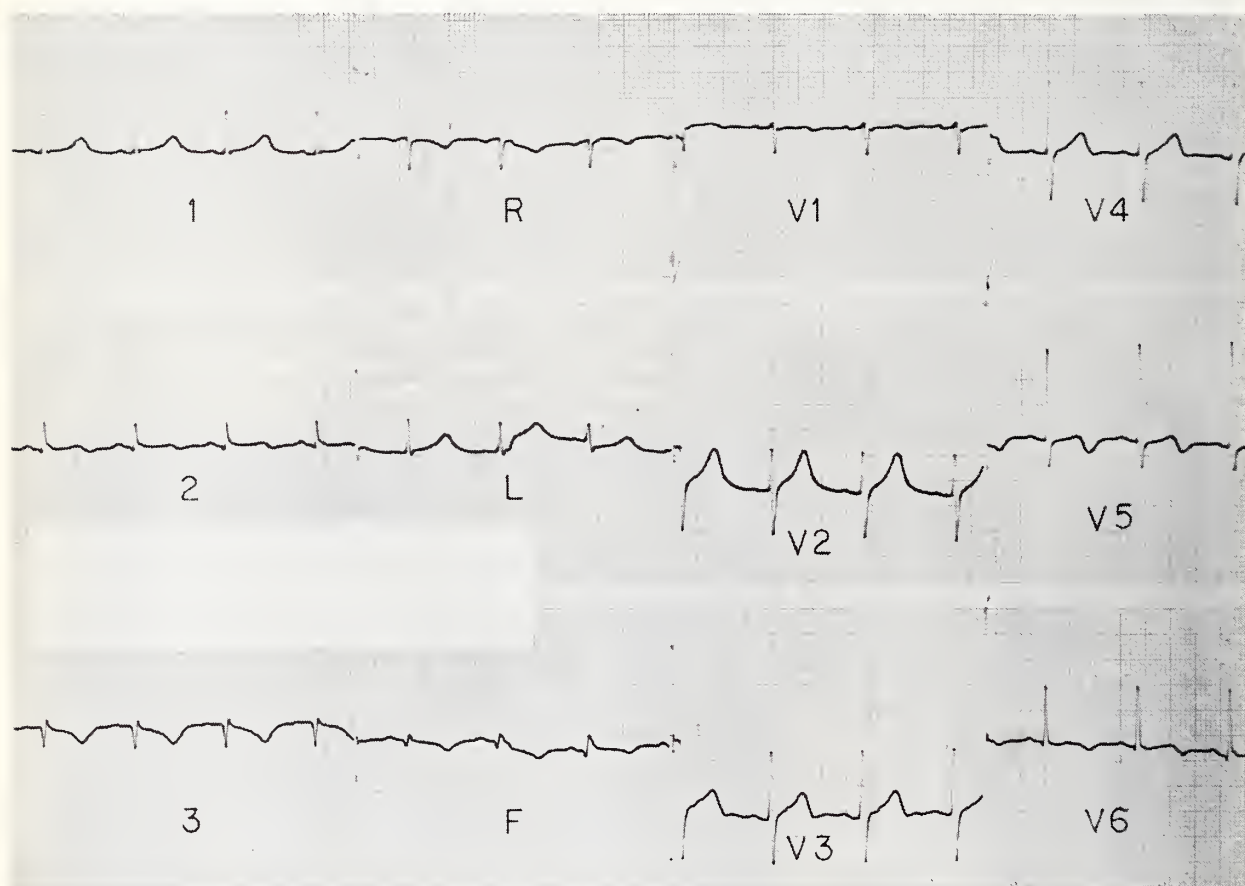
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## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine



A 55-year-old man entered the hospital with a three hour history of crushing, pressure discomfort in his chest and marked nausea. An ECG at that time demonstrated an acute inferior wall myocardial infarction. In the coronary care unit, frequent premature ventricular beats and short runs of ventricular tachycardia remained a problem despite the use of lidocaine intravenously. On the third day, quinidine sulfate was added at a dose of 400 mg every six hours. On this dose of quinidine, with a serum level of 4.1 mg/lit, the intravenous lidocaine was weaned without recurrence of the ventricular ectopic activity. This ECG was taken.

*(Answer on page 444)*



**Questions:**

**1. The ECG demonstrates:**

- A. A recent inferior wall myocardial infarction.
- B. Prolongation of the Q-T interval.
- C. Old anteroseptal wall myocardial infarction.
- D. Left ventricular hypertrophy.
- E. Peri-infarction block.

**2. Electrocardiographic Q-T prolongation has been associated with which of the following:**

- A. Drug effects, eg. quinidine, procainamide, and phenothiazines.
- B. Neurologic diseases, eg. subarachnoid hemorrhage.
- C. A syndrome of congenital deafness and sudden death.
- D. Electrolyte abnormalities, eg. hypocalcemia.
- E. All of the above.

*(Answers on page 444)*

ILLINOIS is the subject of

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## **MEN OF MEDICINE, 1776-1976**

### **PIONEER PHYSICIANS in Illinois**

**L. H. A. NICKERSON, M.D. (1851-1939)**

Doctor Levin A. H. Nickerson died in St. Marys Hospital, March 13, 1939, at the age of 88. Dr. Nickerson continued his professional duties until shortly before his death. He was a member of the Adams County Medical Society for 58 years and a practicing physician for over 60 years.

Dr. Nickerson was born in Camden, Delaware,

January 27, 1851, the son of a prominent New England family. His grandfather Wm. Nickerson, of Norwich, England, came to America in a sailing ship in 1837, landing in Boston. The family located at Yarmouth, making the first of a series of purchases of land from the Indians, the site of which later became the city of Chatham.

Dr. Nickerson's father later located in Camden where he became one of the leading merchants. Dr. Nickerson received his preliminary education in Dover and Wilmington, and later entered the University of Pennsylvania School of Medicine from which he was graduated in 1874. For two years he served as resident physician in the Blockley Municipal Hospital in Philadelphia.

In 1877, Doctor Nickerson came to Quincy, where he built up an extensive practice. For several years he was in charge of Blessing Hospital, and later served as consulting physician for the institution. For many years he was a surgeon for the Wabash Railway and the Army Medical Examining Board. Dr. Nickerson was the president and secretary of the Adams County Medical Society, the oldest medical organization in the state, which was organized here before the Illinois State Medical Society. Dr. Nickerson also served as president of ISMS in 1913-14. He had served as delegate to the AMA of which he was a member for many years.

On September 15, 1880, he was married to Miss Jessie S. Roeschlaub, whose father, Dr. Michael Joseph Roeschlaub, held the distinction of being the oldest practicing physician in Quincy, at that time. The latter was a native of Bavaria and was a practicing physician in Munich before coming to America.

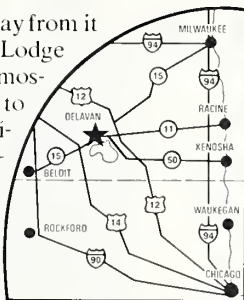
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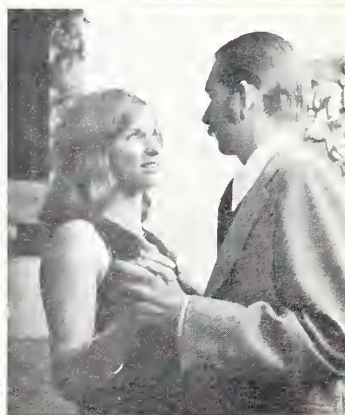
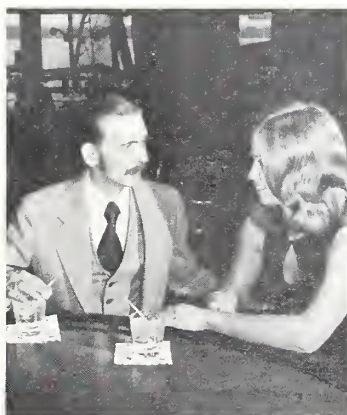
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## report

Illinois Society  
American Association of Medical Assistants

# AAMA Celebrates 20th Anniversary



A workshop for students was given Wednesday. Among those present were students from Triton College with their instructor Judy Miller. The workshop, "After Graduation . . .", arranged by Elvera Fischer, RN, CMA-C, Past National President, went for a full day.



On Thursday a dinner was held in honor of new certified medical assistants. (Left to right) June Hall, Danville, AAMA, Speaker of the House, and Ina Yenerich, CMA-A, educator, celebrate with Cissy Moran, Joliet, who passed the CMA-A exam given Saturday.



Magda Brown, Illinois Society, Past President, and Beverly Hall, Illinois Society, Public Relations Chairman, view one of the exhibits displayed at the convention.

The AAMA celebrated two decades of service and education to the community at their national convention, held September 13 through September 18, 1976, at the Palmer House in Chicago. There were pre-convention activities on Saturday and Sunday, including a certification examination, workshops for educators, and Chicago tours. Sunday evening was highlighted by a festive carnival as Illinoisians welcomed medical assistants from across the nation.

The official opening of the annual meeting on Monday brought greetings from ISMS Presi-

dent, Joseph Skom; Chicago Medical Society, President Herschel Browns; Cook County Commissioner of Health, Dr. Murray Brown, representing Mayor Daley and the City of Chicago; and our Illinois Society President, Ruby Jackson. The AAMA boasts a count of over 18,000 members with 525 local chapters and 46 state societies.

Educational sessions, luncheons and dinners continued daily. The highlight of the week was the President's Dinner on Wednesday evening with the presentation of all state presidents and





Synobia Payne, Chicago, AAMA Registration Chairman and Past President of the Illinois Society gives the delegate count to the House.



Illinois was represented by Ruby Jackson, CMA-A, Chicago, Illinois Society President; Pauline Klarich, Peoria, Illinois Society Past President; Leslie Lee, Chicago, Illinois Society, Speaker of the House; and Vivian Kraft, CMA-A, Bloomington, Illinois Society President-elect, in the AAMA House of Delegates.



Allison Burdick, Sr., M.D., Chicago, Physician Advisor to the Illinois Society, shares in the festive welcome party Sunday evening at the Palmer House. An Illinois medical assistant looks on.

a delightful Anniversary Gala commemorating our 20th year. June Hall, CMA-A, Danville, Speaker of the House, AAMA, was chairman of the 20th Anniversary Gala. At the Awards Luncheon on Thursday, Ruby Jackson, President, Illinois Society, accepted the third place Publication Award for the *Illinois Cardinal*, which is edited by June Hall.

The Friday evening Inaugural Banquet was a formal event. New officers were presented and Laura Lockhart, CMA-A, Ohio, handed the gavel to the new AAMA President, Joan Mi-

chaels, CMA-A, North Carolina. The first official duty of the new president was to preside over the Farewell Breakfast when incoming officers, trustees, and National Convention chairmen were introduced.

Special appreciative acknowledgement is extended to the Illinois State Medical Society Board of Trustees for their generous support in enabling the Illinois Society medical assistants to achieve success in hosting the 20th anniversary convention. ◀

## Medicare and Blue Shield Workshops for Medical Assistants

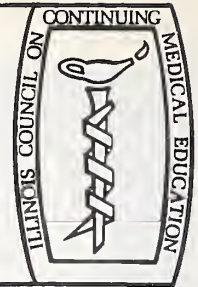
The Blue Shield Plan of Health Care Service Corporation will sponsor several workshops for Medical Assistants this fall.

The schedule is as follows:

Wednesday, October 20, 1976	— Holiday Inn 1501 Sherman Ave.	Evanston, Illinois
Wednesday, October 27, 1976	— Howard Johnson Restaurant 8225 N. Higgins Rd.	Chicago, Illinois
Wednesday, November 3, 1976	— Arlington Park Hilton Rt. 53 at Euclid Rd.	Arlington Hts., Illinois
Wednesday, November 10, 1976	— McCormick Inn 23rd St. at the Lake	Chicago, Illinois
Wednesday, November 17, 1976	— Continental Plaza N. Michigan Ave. at Delaware	Chicago, Illinois
Thursday, November 18, 1976	— Continental Plaza N. Michigan Ave. at Delaware	Chicago, Illinois

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## November, 1976

### Anesthesiology

#### REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING

For: All physicians. 5-day course. November 15-19. Chicago. CME Credit: 40 hrs. AMA Cat. 1. Fee: \$300. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Eugene Meyer. Telephone: (312) 733-2800.

### Auditing Patient Care

#### MEDICAL AUDIT TEAM SEMINAR (BASIC)

For: Physicians and Medical Record Personnel. 2-day workshop. Nov. 4-5, 8:30-4:30 PM. Towers Hotel, Chicago. Speaker: JCAH Clinical Faculty. CME Credit: 13½ hrs. AMA Cat. 1; 12 hrs. American Medical Record Asso. Fee: \$125. Sponsor, contact: Joint Commission on Accreditation of Hospitals, 875 N. Michigan Ave., Chicago 60611. Attn: Mary Ann Evans. Telephone: (312) 642-6061.

#### MEDICAL AUDIT TEAM SEMINAR (ADVANCED)

For: Physicians and Medical Record Personnel. 2-day workshop. Nov. 18-19, Towers Hotel, Chicago. Speaker: JCAH Clinical Faculty. CME Credit: 13½ hrs. AMA Cat. 1; 12 hrs. American Medical Record Asso. Fee: \$125. Sponsor, contact: Joint Commission on Accreditation of Hospitals, 875 N. Michigan Ave., Chicago 60611. Attn: Mary Ann Evans. Telephone: (312) 642-6061.

#### NURSING WORKSHOP ON AUDIT (BASIC)

For: Nursing Staff. 2-day workshop. Nov. 11-12, 8:00 AM-3:30 PM. Towers Hotel, Chicago. Speaker: JCAH Clinical Faculty. CME Credit: 11 contact hrs. ANA; 8 credit hrs. AMRA. Fee: \$115. Sponsor, contact: Joint Commission on Accreditation of Hospitals, 875 N. Michigan Ave., Chicago 60611. Attn: Mary Ann Evans. Telephone: (312) 642-6061.

### Diabetes Mellitus

#### NEW HORIZONS, 1977

For: Physicians and Allied Health Professionals. One-day symposium. Nov. 3, 9:00 AM-3:30 PM. Drake Hotel, Chicago. Main Speaker: Dr. Norbert Freinkel. CME Credit: AAFP Elective; American Dietetic Asso. and Ill. Nurses Asso. Fee: \$15-Physicians not members of ADA; \$10-allied health prof. not members of ADA; free to members of ADA. Reg. Deadline: Oct. 28. Sponsor, contact: American Diabetes Asso., Greater Chicago and Northern Ill. Aff., 620 N. Michigan Ave., Chicago 60611. Attn: Florence Narodick. Telephone: (312) 943-8668.

### Early Breast Cancer Detection Methods

#### 2ND MID AMERICAN BREAST CANCER SYMPOSIUM

For: Physicians. Symposium. Nov. 5-6, 8:30 AM-5:30 PM. Concourse Hotel, Madison, Wisconsin. Speaker: Dr. Robert Egan. CME Credit: 12 hrs. AMA Cat. 2. Fee: \$75. Reg. Limit: 300. Reg. Deadline: Oct. 15. Sponsor, contact: Wisconsin Breast Cancer Detection Foundation, Inc., 7803 Mineral Point Rd., Madison, Wisconsin 53717. Attn: Paula Hobbins. Telephone: (608) 831-2300. Co-sponsor: National Association for Cancer Detection.

### Human Relations in Medicine

#### HUMAN RELATIONS TRAINING:

##### A WORKSHOP FOR PHYSICIANS

For: All MDs 1-hour workshop. Nov. 2, 7:45-9:00 AM. Copley Memorial Hospital, Aurora. Speaker: Michael R. Neboschick, Ph.D. CME Credit: 1 hr. AMA Cat. 1; AAFP Elective. Fee: None. Reg. Limit: 30. Reg. Deadline: Oct. 19. Sponsor, contact: Copley Memorial Hospital, Lincoln & Weston Aves., Aurora, IL 60507. Attn: Julius Newman, M.D., Medical Director. Telephone: (312) 897-6021.

### Laryngology and Bronchoesophagology

#### COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY

For: Physicians. 6 day course. November 1-6, 8:00 AM-5:00 PM. Eye and Ear Infirmary, Chicago. Speaker: Paul H. Holinger, M.D. CME Credit: 45 hrs. AMA Cat. 2. Fee: \$350. Reg. Limit: 20. Sponsor, contact: University of Illinois, Dept. of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Ave., Chicago, IL 60612. Attn: Mrs. W. B. Wickland. Telephone: (312) 996-6582.

### Marital Therapy (Divorce)

#### FOURTH ANNUAL FALL CONFERENCE: CREATIVE DIVORCE

For: Physicians and mental health professionals. Two-day workshop. November 11-12, 9:00 AM-4:30 PM. Norris Center, McCormick Auditorium, 1999 Sheridan Road, Evanston. Speaker: Mel Krantzler, M.S., Dir. Creative Divorce Nat'l Counseling Center, San Rafael, CA. CME Credit: 14 hrs. AMA Cat. 1. Fee: \$70. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

### Medical/Surgery

#### NINTH MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY

For: Physicians, dentists, nurses, pharmacists. Seminar-Symposium. Nov. 17, 8:45 AM-1:00 PM. Mother Leonarda Hall, St. Therese Hosp., Waukegan. CME Credit: 5 hrs. AMA Cat. 1; AAFP Elective. Fee: None. Reg. Deadline: Nov. 15. Sponsor, contact: St. Therese Hosp., 2615 Washington, Waukegan, IL 60085. Attn: R. M. Adelman, D.D.S., M.D. Telephone: (312) 688-6461.

### Pediatric Neurology

#### CLINICAL ADVANCES IN PEDIATRIC NEUROLOGY

For: Pediatricians, Neurologists. 2-day continuing education course. November 8-9. Holiday Inn Central, Milwaukee, Wisconsin. Speaker: Jerome V. Murphy, M.D. CME Credit: 12 hrs. AMA Cat. 1. Fee: \$125. Reg. Limit: 120. Sponsor, contact: Medical College of Wisconsin, Office of Continuing Education, 561 N. 15th St., Milwaukee, Wisconsin 53233. Attn: Edwin O. Hirsch, M.D. Telephone: (414) 272-5450, ext. 335.

### Psychiatry

#### PRIVATE TRANSFORMATION AND PUBLIC FALLOUT

For: Professionals and Students of the Health Field. Lecture. Nov. 3, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. Speaker: Montague Ullman, M.D., Brooklyn. CME Credit: 2 hrs. AMA Cat. 1. Fee: \$15 prof.; \$5 student. Reg. Limit: 100. Reg. Deadline: advance registration requested. Sponsor, contact: Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D. Telephone: (312) 827-8811.

#### GENESIS OF THE THERAPIST'S SELF:

##### ITS IMPACT ON PATIENTS AND PEERS

For: Professionals and students in the health field. Lecture Series. November 3, January 12, February 2, March 2, and April 13. Forest Hospital, Des Plaines. CME Credit: 2 hrs. per lecture AMA Cat. 1. Fee: Series, \$90; Each lecture, \$15. Reg. Deadline: Entire Series before Oct. 6. Sponsor, contact: Leo Jacobs, M.D., Director of Medical Education, Forest Hospital and Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Telephone: (312) 827-8811.

### ILLINOIS PSYCHIATRIC SOCIETY 3RD ANNUAL FALL WEEKEND MEETING

For: Psychiatrists and other interested professionals. Symposia, workshops, lectures and film presentations. November 5-7, 6:00 PM Friday-Sunday noon. O'Hare Marriott, Higgins and Cumberland Roads, Chicago. CME Credit: 15 hrs. AMA Cat. 1. Fee: \$30. Reg. Deadline: November 1. Sponsor, contact: Illinois Psychiatric Society, 55 East Monroe, Suite 3510, Chicago, IL 60603. Attn: Wendy Smith. Telephone: (312) 782-1654.

### THE CRY FOR HELP

For: Mental health care professionals. Lecture. Nov. 17, 1:00-4:00 PM. Riveredge Hospital, Forest Park. Speaker: Edwin Shneidman, Ph.D., UCLA. Fee: \$10. Reg. Limit: 200. Reg. Deadline, Reservations (771-7000 ext. 342). Sponsor, contact: Riveredge Hospital, 8311 West Roosevelt Rd., Forest Park, IL 60130. Attn: John Pontarelli. Telephone: (312) 771-7000 ext. 305.

### THERAPEUTIC VECTORS IN SCHIZOPHRENIA

For: Psychiatrists. Distinguished guest lecture. Nov. 17, 8:00 PM. Offield Auditorium, Passavant Hospital, Chicago. Speaker: Robert Cancro, M.D., Connecticut. CME Credit: 1½ hrs. AMA Cat. 1. Fee: None. Sponsor, contact: Institute of Psychiatry, 320 E. Huron, Chicago 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058. Co-sponsor: Northwestern University Medical School.

### Radiology in Otolaryngology & Ophthalmology

#### THE TENTH ANNUAL CONFERENCE ON RADIOLOGY IN OTOLARYNGOLOGY & OPHTHALMOLOGY

For: Radiologists. 2-day conference. Nov. 12 & 13, 8:00 AM-5:00 PM each day. Illinois Eye & Ear Infirmary, Chicago. Speaker: Dr. Galdino Valvassori. CME Credit: 15 hrs. AMA Cat. 1. Fee: \$120; \$60 resident; \$50 Sat. afternoon session only. Reg. Limit: 120. Reg. Deadline: Nov. 1. Sponsor, contact: University of Illinois College of Medicine, Office of Continuing Education Services, 1853 W. Polk St., Room 144, Chicago 60612. Attn: JoAnn Kohn. Telephone: (312) 996-8025. Co-sponsor: American College of Radiology.

### Skin Infections

#### ANNUAL POST-GRADUATE ASSEMBLY OF SOUTHERN ILLINOIS MEDICAL ASSOCIATION

For: All physicians of Illinois—especially Southern Illinois. Annual postgraduate meeting. Nov. 4, Registration 8:00 AM, Morning Session 9:00 AM (Chemotherapy), Luncheon 12:30 PM, Afternoon Session 2:30 PM (Oncology), Belle-Clair Fairgrounds, Belleville. Speaker: Roy Page, M.D., Univ. of Tennessee. CME Credit: 4 hrs. AMA Cat. 1. Sponsor, contact: Southern Illinois Medical Association, Suite 3-E, 6401 W. Main St., Belleville, IL 62223. Attn: Dale Rosenberg, M.D., Exec. Secy-Treas. Telephone: (618) 398-5600.

### Utilization Review

#### SEMINAR ON UTILIZATION REVIEW

For: Physicians and Utilization Review Coordinators. One-day workshop. Nov. 17, 8:30 AM-4:30 PM. Towers Hotel, Chicago. Speaker: JCAH Clinical Faculty. CME Credit: 7½ hrs. AMA Cat. 1; 5 hrs. American Medical Record Association. Fee: \$90. Sponsor, contact: Joint Commission on Accreditation of Hospitals, 875 N. Michigan Ave., Chicago 60611. Attn: Mary Ann Evans. Telephone: (312) 642-6061.



## MEDICINE FOR Today—

### Fall Sessions

**For:** Practicing physicians in all specialties. IAFP's 27th Annual Lecture Series, with A-V and Q&A supplement. Emphasis on Neurology, Dermatology, Oncology, & Cardiology. **CME Credit:** 30 hrs. AAFP Prescribed, AMA Category 1. **Fee:** \$100 AAFP mbrs., \$110 non-mbrs. Meets in these cities on dates noted:

*Belleville*—Oct. 21, 28, Nov. 4, 11, 18, Dec. 2.

*Berwyn*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Beverly*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Centralia*—Oct. 20, Nov. 3, 17.

*Champaign*—Oct. 21, 4, 18.

*Chicago Nearwest*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Chicago North*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Chicago Southwest*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Harvey*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Hinsdale*—Oct. 27, Nov. 10, Dec. 1.

*Melrose Park*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Park Ridge*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Peoria*—Oct. 21, Nov. 4, 18.

*Rockford*—Oct. 28, Nov. 11, Dec. 2.

*Rock Island*—Oct. 21, Nov. 4, 18.

*Springfield*—Oct. 26, Nov. 11.

For details of time and place, contact: Illinois Academy of Family Physicians, 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604. Telephone: (312) 427-5314.

## Internal Medicine (Cardiology)

### PERICARDITIS AND CHEST PAIN

**For:** Physicians, Residents, Interns. Lecture. December 1. Martha Washington Hospital, Chicago. **Speaker:** Alfred Soffer, M.D., Editor-in-Chief of the journal, Chest; Executive Director, American College of Chest Physicians. **CME Credit:** 1 hr. AMA Cat. 1; AAFP Prescribed. **Sponsor, contact:** Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618. Attn: Fernando Villa, M.D., Medical Director. Telephone: (312) 583-9000 ext. 331.

## Internal Medicine (Nephrology/Renal)

### FLUID & ELECTROLYTE BALANCE, HYPERTENSION & RENAL DISEASE

**For:** Practicing Internists and General Practitioners. 5-day postgraduate course. Dec. 6-10, 9:00 AM-5:00 PM daily. Northwestern Memorial Hospital, Chicago. **CME Credit:** 22 hrs. AMA Cat. 1; AAFP Prescribed. **Fee:** ACP Members, FACP, Residents \$140; Non-Members \$200; ACP Associates \$70. **Sponsor, contact:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. Telephone: (215) 243-1200 ext. 220. Attn: Linda M. Salsinger, Registrar. Co-Sponsors: Northwestern Univ. Medical School and Northwestern Memorial Hospital.

## Primary care

### ISSUES IN PRIMARY CARE

**For:** Physicians, Hospital Administration, Health Care Field, Nurses. One-day Workshop. December 3, 8:00 AM-5 PM. Continental Plaza Hotel, Chicago. **Speakers:** Outstanding speakers in field; program to be announced. **CME Credit:** 9 hrs. AMA Cat. 1; AOA. **Fee:** \$45. **Reg. Limit:** 400. **Sponsor:** The Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago 60604. **Contact:** The Julian J. Jackson Agency, Louis B. Kuhn, 919 N. Michigan Ave., Chicago 60611. (Workshop Coordinators). Telephone: (312) 944-5144.

## Psychiatry

### UNDERSTANDING PEOPLE THROUGH TRANSACTIONAL ANALYSIS

**For:** Mental health care professionals. Lecture. Dec. 15, 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker:** Thomas Harris, M.D., Author of "I'm OK, You're OK . . ." **Fee:** \$10. **Reg. Limit:** 200. **Reg. Deadline:** Reservations (771-7000 ext. 342). **Sponsor, contact:** Riveredge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations. Telephone: (312) 771-7000 ext. 305.

### PERSPECTIVES IN LAW AND PSYCHIATRY

**For:** Psychiatrists. Distinguished lecture series. Dec. 15, 8:00 PM. Offield Auditorium, Passavant Hospital, Chicago. **Speaker:** Irwin Perr, M.D., Prof. of Psychiatry, Rutgers Med. School. **CME Credit:** 1½ hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Institute of Psychiatry, 320 E. Huron, Chicago 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058. Co-sponsor: Northwestern Univ. Med. School.

## Would an Outside View Help your Hospital CME?

The Illinois Hospital CME Consultation service can improve your in-hospital CME by helping you to build an up-to-date conception designed to enhance individual physicians' full clinical potential—and discard stereotyped group efforts to "keep up." The two-part process begins with self-analysis using a unique 16-page booklet—FREE to Illinois hospitals. The second part involves a personal visit and report by an expert on effective in-hospital CME; for the Consultant's visit, a modest charge is necessary to cover his honorarium, travel, and related costs.

For full information, ask for the "Consultation booklet"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

January, 1977

## Family Therapy

### A DAY WITH MURRAY BOWEN

**For:** Physicians and Mental Health Professionals. One-day workshop. Friday, Jan. 21, 9:00 AM-4:30 PM. **Speaker:** Murray Bowen, M.D., Georgetown Univ. Hospital, Washington, D.C. **CME Credit:** 7 hrs. AMA Cat. 1. **Fee:** \$35.00. **Sponsor, contact:** The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-Sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

## Psychiatry

### PERIPATETIC QUEST FOR KNOWLEDGE

**For:** Professionals and Students in the Health Field. Lecture. Jan. 12, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. **Speaker:** Shervert Frazier, Jr., M.D., Harvard Univ. **CME Credit:** 2 hrs. AMA Cat. 1. **Fee:** \$15 prof., \$5 student. **Reg. Limit:** 100. **Reg. Deadline:** advance registration requested. **Sponsor, contact:** Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D. Telephone: (312) 827-8811.

### SCHIZOPHRENIC COMMUNICATIONS

**For:** Mental health care professionals. Lecture, Jan. 19, 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker:** Gregory Bateson, Senior Lecturer, Kresge College, Univ. of Cal. **Fee:** \$10. **Reg. Limit:** 200. **Reg. Deadline:** Reservations (771-7000 ext. 342). **Sponsor, contact:** Riveredge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations. Telephone: (312) 771-7000 ext. 305.

## Psychiatry

### ETHICAL DISCIPLINE IN THE APA

**For:** Psychiatrists. Distinguished guest lecture series. Jan. 19, 8:00 PM. Offield Auditorium, Passavant Hospital, Chicago. **Speaker:** Robert A. Moore, M.D., Chairman, Comm. on Ethics, Amer. Psychiatric Asso. **CME Credit:** 1½ hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Institute of Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago. Attn: Jeanne Smith. Telephone: (312) 649-8058.

## CME Planning Aids

ICCME continually develops a variety of "how-to" material for CME Planners—DME's, program chairmen of hospitals and medical societies (both specialty and geographic), and others. All items are FREE to Illinois physicians and CME sponsors.

To learn what's currently available, request the "CME Planning Aids Order Form"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Have You Seen the New Illinois Mandatory CME Law?

Last November, the Illinois Legislature passed a law requiring continuing medical education for re-licensure. The law will be administered by the State Department of Registration and Education. FREE copies of the law are available; write or call . . .

Illinois Council/CME  
55 East Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Burns

### TREATMENT OF MINOR TO MODERATE BURNS

**For:** Physicians and Nurses. Symposium. Dec. 8, 9:00 AM-2:00 PM. Mother Leonarda Hall, St. Therese Hospital, Waukegan. **Speaker:** Alan Dimick, M.D., Asso. Prof. of Surgery, Univ. of Alabama. **CME Credit:** 5 hrs. AMA Cat. 1; AAFP Elective; Illinois Nurses Asso. **Reg. Deadline:** Dec. 7. **Sponsor, contact:** St. Therese Hospital, 2615 W. Washington, Waukegan, IL 60085. Telephone: (312) 688-6461. Attn: R. M. Adelman, D.D.S., M.D. Co-Sponsors: R. M. Adelman, D.D.S., M.D. and Marguerite Turpel, R.N.

## Family Therapy

### PROBLEM-CENTERED FAMILY THERAPY

**For:** Physicians and Mental Health Professionals. Two-day Workshop. Thursday, Dec. 2 and Friday, Dec. 3, 9:00 AM-4:30 PM. Chicago, IL. **Speaker:** William Pinsof, M.A. F.I.C./C.F.S. staff, Chicago. **CME Credit:** 14 hrs. AMA Cat. 1. **Fee:** \$60. **Reg. Limit:** 50. **Sponsor, contact:** The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

# Live a little history while you learn a lot of new medicine

American Medical Association's 30th Clinical Convention • Scientific Program  
December 4-7, 1976/Philadelphia Civic Center, Philadelphia, Pa.



## AMA's 30th Clinical Convention • December 4-7, 1976 • Philadelphia Civic Center

Please print and return to:

**AMA Department of Meeting Services**  
535 North Dearborn Street  
Chicago, Illinois 60610

### General Registration

- ☐ AMA members and their guests: no fee  
☐ Non-member physicians: \$35  
☐ Guests of non-members: \$10 per person  
☐ Medical students, interns, residents, Canadian, and foreign physicians: no fee

**Does not include CME Course, Sessions, or Luncheons Fees.**

I am a member of the AMA through the following  
State Medical Association or government service

If not, I have added \$35 non-member fee to my  
course registration remittance of \$\_\_\_\_\_,  
which is enclosed in the form of a check or money  
order payable to the American Medical Association.  
I understand payment must accompany my  
choice of course(s) on this registration coupon.

Confirmation of my selection(s) will be mailed  
to me according to the deadlines itemized. Please  
send AMA's Philadelphia Clinical Convention  
Brochure ☐.

Name \_\_\_\_\_

Office Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Office Phone No. \_\_\_\_\_

Course Code	Credit Hours	Fees	Number of Preferences			
			Sat.	Sun.	Mon.	Tue.
S-1.	5	\$ 50	___	___	___	___
S-2.	6	60	___	___	___	___
S-3.	6	60	___	___	___	___
S-4.	6	60	___	___	___	___
S-5.	3	30	___	___	___	___

S-6.	3	30	___
S-7.	5	50	___
S-8.	3	30	___
S-9.	3	30	___
S-10.	3	30	___
S-11.	11	130	___
S-12.	6	60	___
S-13.	6	60	___
S-14.	6	60	___
S-15.	6	60	___
S-16.	6	60	___
S-17.	3	30	___
S-18.	3	30	___
S-19.	3	30	___
S-20.	3	30	___
S-21.	3	30	___
S-22.	3	30	___
S-23.	12	120	___
S-24.	6	60	___
S-25.	6	60	___
S-26.	3	30	___
S-27.	3	30	___
S-28.	3	30	___
S-29.	3	30	___
S-30.	3	30	___
S-31.	3	30	___
S-32.	6	60	___
S-33.	6	60	___
S-34.	6	60	___
S-35.	6	60	___
S-36.	6	60	___
S-37.	5	50	___
S-38.	3	30	___
S-39.	3	30	___
S-40.	3	30	___
S-41.	3	30	___
S-42.	3	30	___
S-43.	5	50	___
S-44.	3	30	___
S-45.	3	30	___
S-46.	3	30	___

Add \$35 if Non-AMA Member \_\_\_\_\_

TOTAL \_\_\_\_\_

**Special Note** • In addition to the postgraduate courses outlined here, the Oct. 11, 1976, JAMA Convention Issue contains 9 general sessions, 16 luncheon sessions, and 32 "Meet the Professor" meetings available to you. The AMA's Philadelphia Clinical Convention Brochure also contains this information. All inquiries should be directed to the AMA Department of Meeting Services, 535 N. Dearborn St., Chicago, IL 60610 and/or direct phone inquiries to: AMA Department of Meeting Services (312) 751-6187.



**CME program tailored to your needs** • The primary purpose of the AMA Clinical program is to provide you with a self-paced, multidisciplinary learning experience which is not available in specialty society continuing medical education (CME) programs. For this purpose, the program features an exceptionally large and broad selection of Category 1 postgraduate courses which provide credits toward the AMA Physician's Recognition Award. In fact, the program is the largest ever offered at an AMA National Convention.

In Category 1, you can choose from 46 postgraduate courses, 9 general sessions, telecourses, living teaching demonstrations, and conducted exhibit rounds. In addition, Category 2 credits can be obtained by paid attendance at 16 luncheon and 32 "Meet the Professor" sessions.

**Plan Now for Your CME in Philadelphia** • Use the coupon to register now for the postgraduate courses of your choice. The complete selection and full descriptions of the 103 CME events will be available in the October 11, 1976, Clinical Convention Issue of the **Journal of the American Medical Association (JAMA)**. You may also check the coupon box to receive the AMA's Philadelphia Clinical Convention Brochure which has material similar to the JAMA Convention Issue. After filling in information, send the coupon to the AMA with your accompanying check or money order. Advance registration requests must be received by October 29, 1976. Course tickets and registration

**The Bicentennial City** • It is particularly appropriate in this Bicentennial Year that Philadelphia be the site of AMA's 30th Clinical Convention. Because Philadelphia is not only the birthplace of our Nation, but it can also lay legitimate claim to being the cradle of American medicine. It is the site of the first hospital, the first medical school, and the home of many famous American Colonial physicians, such as Benjamin Rush, John Shippen, and John Morgan.

In your off hours, you can step back into history with visits to Independence Hall, the new Liberty Bell Pavilion, Betsy Ross' House, the Franklin Institute, and many other historical sites. For all of its historical significance, Philadelphia is as modern and sophisticated a city as there is. There's a multitude of superb restaurants to delight the gourmet, including the Old Original Bookbinder's.

materials will be sent to you on November 12, 1976. All tickets requested after that deadline date will be held for pickup at the Postgraduate Registration Desk in the Philadelphia Civic Center.

If the minimum course registration is not attained for your first choice, or if the course is full, one of your alternate choices will be substituted. It is best to register early because the class sizes are limited. All medical students, interns, and residents are entitled to a 50% discount on postgraduate course fees (\$10 per Category 1 credit hour is standard rate).

## Postgraduate Courses

### Tuesday, Dec. 4, 1976

8:00 AM-Noon (5 hours: \$50)

S-1. Basic Life Support (Cardiopulmonary Resuscitation—CPR)

2:30-5:30 PM (6 hours: \$60)

S-2. Practice Management Seminar

S-3. Writing for Scientific Journals

S-4. Nutrition: Parenteral & Alimentary

8:00 AM-Noon (3 hours: \$30 each)

S-5. Basic Electrocardiography

S-6. Evaluation of the Dizzy Patient

5:30-8:30 PM (5 hours: \$50)

S-7. Basic Life Support (CPR)

8:30-11:30 PM (3 hours: \$30 each)

S-8. Hematologic Disorders in Children

S-9. The Eye & Office Practice

S-10. Coronary Artery Disease: Medical vs Surgical Therapy

### Wednesday, Dec. 4 & Sunday, Dec. 5

8:00 AM-5:30 PM & 9:00 AM-Noon (11 hours: \$110, plus lab fee = \$130)

S-11. Public Speaking Seminar

8:00 AM-Noon & 9:00 AM-Noon (6 hours: \$60 each)

\*S-12. Fluid & Electrolyte Therapy

S-13. Diseases of the Bowel

S-14. Arthritis Update: Medical & Surgical Management

8:30-11:30 PM & 2:30-5:30 PM (6 hours: \$60 each)

\*S-15. Management of Diabetes Mellitus

S-16. Hypertension

### Monday, Dec. 5, 1976

8:00 AM-Noon (3 hours: \$30 each)

S-17. Diagnosis & Treatment of Fractures of the Upper Extremities

\*S-18. Advanced Electrocardiography

S-19. Emergency Medicine

5:30-8:30 PM (3 hours: \$30 each)

\*S-20. Pulmonary Function & Blood Gases

S-21. Behavioral Problems Involving Children & Adolescents

S-22. Recent Advances in Cancer Surgery

### Tuesday, Dec. 5 & Monday, Dec. 6

8:30 AM-5:30 PM & 7:30 AM-Noon (12 hours: \$120)

S-23. Advanced Life Support (CPR)

9:00 AM-Noon & 9:00 AM-Noon (6 hours: \$60)

S-24. Jaundice: Diagnosis, Treatment & Management

2:30-5:30 PM & 9:00 AM-Noon (6 hours: \$60)

S-25. Everything You Want to Know About New Diagnostic Techniques: Scoping, Scanning, & Angiography

### Monday, Dec. 6, 1976

9:00 AM-Noon (3 hours: \$30 each)

S-26. Diagnosis & Treatment of Fractures of the Lower Extremities

S-27. Neonatology

S-28. Current Controversies in Gynecology

2:30-5:30 PM (3 hours: \$30 each)

S-29. Basic Electrocardiography

S-30. Pulmonary Function & Blood Gases

\*S-31. Complications of Psychotropic Drugs

### Monday, Dec. 6 & Tuesday, Dec. 7

9:00 AM-Noon & 9:00 AM-Noon (6 hours: \$60 each)

S-32. Immunology 1976

S-33. Thromboembolism: Prevention, Diagnosis, & Treatment

2:30-5:30 PM & 2:30-5:30 PM (6 hours: \$60 each)

S-34. Fluid & Electrolyte Therapy

S-35. Nutrition: Parenteral & Alimentary

S-36. Management of Diabetes Mellitus

### Tuesday, Dec. 7, 1976

7:30 AM-Noon (5 hours: \$50)

S-37. Basic Life Support (CPR)

9:00 AM-Noon (3 hours: \$30 each)

S-38. Diagnosis & Treatment of Fractures in Children

S-40. Allergic Emergencies

S-41. Medical Problems in Long-Term Care

S-42. Acute Hand Problems

1:00-5:30 PM (5 hours: \$50)

S-43. Basic Life Support (CPR)

2:30-5:30 PM (3 hours: \$30 each)

S-44. Advanced Electrocardiography

S-46. Complications of Psychotropic Drugs

\*Course repeated. See course list for dates & times.



# PHYSICIAN opportunities

**Oak Forest Hospital**  
has board eligible physician openings.

**Consider the following in making your future plans:**

- ✓ Accredited, 1700 bed long term care facility: acute care, intensive rehabilitation unit, chronic disease hospital, intermediate care, outpatient services, community health network.
- ✓ Excellent opportunities in clinical medicine, teaching, research and administration.
- ✓ Opportunities for faculty positions in Chicago area medical schools for qualified applicants.
- ✓ Wide range of specialized and consultant services available at Oak Forest and its affiliate institution, Cook County Hospital.
- ✓ Inservice, seminar and convention attendance opportunities. Accredited by the Illinois Council on Continuing Medical Education.
- ✓ Competitive salary and benefit program.
- ✓ Malpractice coverage is made available without charge to the physician.

## **CURRENT VACANCIES:**

- **ORTHOPEDIC SURGEON**
- **BOARD ELIGIBLE PHYSICIAN**

(Full or Part Time for our Community Medicine Department)

Physicians interested in learning more about these opportunities by visiting the hospital with traveling expenses reimbursed, please contact:

**Medical Director**  
**Telephone: (312) 928-4200, ext. 2202**



## **Oak Forest Hospital**

15900 S. Cicero Avenue Oak Forest, Illinois 60452

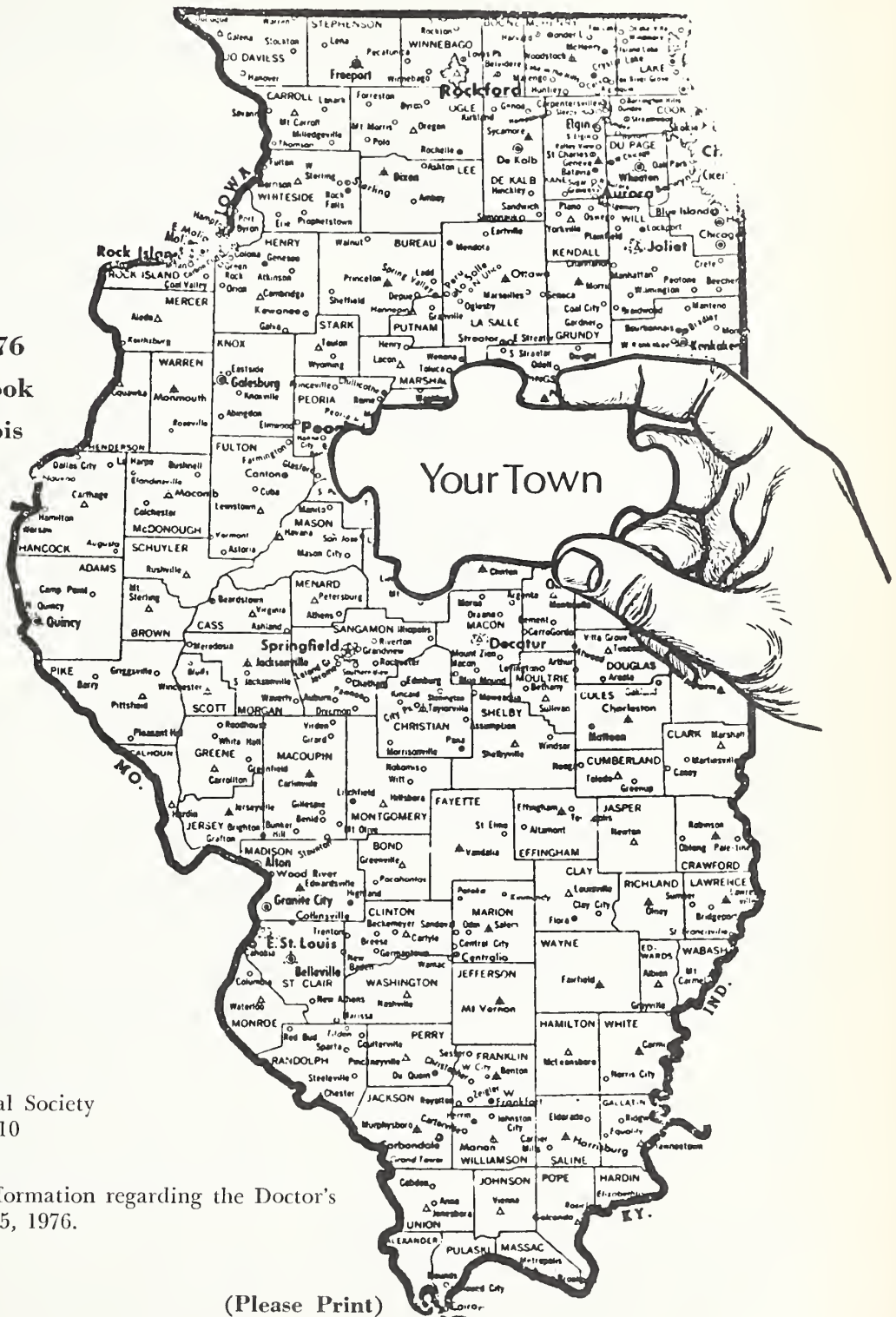
An Equal Opportunity Employer M/F



# PUT YOUR TOWN ON THE MAP

## HELP COMPLETE THE MEDICAL CARE PICTURE

December 5, 1976  
 Sheraton Oakbrook  
 Oakbrook, Illinois



**Doctor's Job Fair**  
 Illinois State Medical Society  
 55 E. Monroe—#3510  
 Chicago, IL 60603

Please send more information regarding the Doctor's  
 Job Fair, December 5, 1976.

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARLINGTON HEIGHTS:** Board Certified Family Practitioner wishes associate who is Board certified or eligible in Family Practice. Modern office located across from Community hospital. Liberal salary and time off for study and vacations. Partnership after one year. Send resume to: Dr. Alan M. Hollett, 605 W. Central Rd., Arlington Heights 60005. (12)

**BLOOMINGTON:** Two active Internists seek Family Practitioners and Pediatricians to join evolving private group of primary-care practitioners. Group to consist of six physicians leasing office space in Hospital-owned building. Organized within a Community Health Center setting. Contact: Michael Daniloff, Vice-President, Professional Services, Mennonite Hospital, 807 North Main Street, Bloomington, 61701 (309) 828-5241. (3)

**CAIRO:** F.P. and internist sought. Rural service area—20,000 population. Excellent salary. Fringe benefits including malpractice. Office and staff provided. Med staff privileges in 62 bed acute hospital with peds, OB/GYN, and surgery specialties. Excellent recreation—fishing, hunting, tennis, golf. Private and public schools. Jr., 4 yr. and Med schools nearby. Contact: N. Pettry, 2020 Cedar, Cairo. 618-734-2400. (1)

**CARBONDALE:** Family physician: Innovative Neighborhood Health Center in Southern Illinois seeks Family Practice Physician to provide patient care and supervise other professionals, para-professionals in clinic setting. Salary negotiable. Position available October 1976. Write: Robert Stalls, Director of Human Resources, City of Carbondale, 602 E. College Street, Carbondale, Illinois 62901, (618) 549-5302. (2)

**CHICAGO:** Medical center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice. Contact: F. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625, 312-478-6000 (2)

**CHICAGO:** Internist: board certified, wanted for association with hospital based medical/surgical group. Very large, active practice. North side Chicago. Unusual opportunity. Write Mr. C. M. Rappaport, Director of Personnel, 5700 North Ashland Avenue, 60660. (12)

**CHICAGO:** Comprehensive Health Care Center in the Metropolitan Chicago area has positions available for primary health care physicians. Center is located in close proximity to Community Hospital. Regularly scheduled hours. Financial arrangements will be discussed and will be commensurate with qualifications. Write or call: P. Pratscher, c/o Joliet Community Medical Center, 450 Prairie, Calumet City, IL 60409, Phone (312) 862-3100. (11)

**CHICAGO:** Physician needed for well established, ultra modern medical center. Full laboratory and X-ray. Congenial working conditions and excellent co-workers. Good hospital associations. No evenings or weekends. Clinic located south side, near lake. Contact, Mr. Lawrence, Booker Family Health Care Center, 747 E. 47th, Chicago, 60653. (312) 624-4800. (1)

**CLINTON:** Population 8500. Opening for solo general practice. Four physicians in General Practice at present. Twenty-five miles from Decatur and Bloomington. Office Available. Recreational facilities excellent. Clinton Nuclear Power Plant under construction 6 mi. east of City. Contact: M. J. Hein, 422 West White, Clinton 61727, AC 217-935-3171. (2)

**COLLINSVILLE-EDWARDSVILLE:** Progressive towns, 15 miles from Downtown St. Louis. Ample recreational facilities, S.I.U. Campus nearby. New Community Hospital will open this summer. Need a qualified Ophthalmologist. No initial investment needed. Excellent opportunity for the future. Contact Mrs. Hall, 657 E. Broadway, East St. Louis 62205, (618-345-0417). (12)

**FAIRFIELD:** Group of 4 physicians, GP, gen. surgeon, Gyn.-OB, and pediatrician, looking for another OB-Gyn. man. Population 6500, excellent hospital facilities, generous salary and all the benefits of corporation assured. Illinois license. Contact S. W. Konarski, M.D., 101 E. Center St., Fairfield, 62837, 618-842-2187. (12)

**FORT MADISON, IOWA:** Opening for 2 FP/GP, OB, Int. in growing industrial city of 16,000 serving 70,000 on Miss. River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, XInt, living area, 125 bed accredited hospital. Contact Donald A. Buckert, Sacred Heart Hospital, Fort Madison, Ia. 52627. 319-372-6530. (12)

**ILLINOIS:** Variety of settings in agencies providing diagnostic, treatment, consultative and advisory services or administrative direction to medical programs. Completion of approved Medical school and 1 year internship/residency in approved hospital required. Must possess or acquire appropriate valid Illinois license before employment. Temporary certification not acceptable. Salary commensurate with skills and experience—Good benefits. Equal Opportunity Employer—Male or Female. Send resume to: Robert P. Gosnell, Manager, Counseling Services and Administrative Recruitment, Illinois Department of Personnel, 521 State Office Building, Springfield, Illinois 62706. (1)

**JOHNSTON CITY:** Southern Illinois—population 4,000 near I-57. Family practice available. Full equipped office. Surgeon in clinic. Possible partnership available. Hospital 6 miles away. 20 miles to SIU. 100 miles to St. Louis Mo. Contact: Mrs. R. A. Rupprecht, 401 N. Allyn St., Carbondale, 62951 (618) 549-3093 (11)



**JUSTICE:** One or two good Family Practitioners needed: lovely new Medical Center (Southwest), on-site Surgery Center, X-Ray, Laboratory, Emergency Room and Pharmacy; complete staff 15 doctors for various specialties who are on staff at nearby 500 bed hospital. Opportunity for future partnership. Contact Dr. E. I. Breslar, Forest Hill Medical Center, 9050 W. 81st, Justice 60458. 312-594-3500. (2)

**McHENRY:** We have openings available for Board Certified or eligible OB-GYN, Pathologist and Orthopaedic physicians on the staff of our 23 physician multispecialty group. Incentive pay from day one with minimum guaranteed draw, malpractice paid, partnership after 1-2 years, excellent fringe benefits. We are 55 miles northwest of Chicago in the Chain-o-Lakes resort area. The Medical Group is physically adjacent to a 147 bed general community hospital and State Trauma Center. Jim Dickson, Personnel Director, McHenry Medical Group, McHenry 60050. (815 385-1050 ext. 332. (2)

**OLNEY:** ENT, Internal Medicine, Dermatology, Ophthalmology needed. 26 MD multispecialty partnership, 15,000+ referral population, new bldg., 1st yr. earnings guaranteed, 200 bed modern hospital, 4 wks. vacation, 3 wks. meeting per yr. Contact: David L. Potter, Adm., Weber Medical Clinic, 1200 N. East St., Olney 62450 (618) 395-4311. (2)

**ORLAND PARK:** Orland Park and far S.W. Chicago office, need general practice physicians, complete facilities both offices. New office bldg. completed Dec. 1, 1976. Contact: C. E. Cornelison, Adm., 10444 S. Kedzie, Chicago 60655, (312) 239-3000. (1)

**OLNEY:** Radiologist to head a new department with another radiologist in a 150 bed hospital with 50 bed addition under construction. Recreational facilities nearby. Community of 10,000. Method of compensation negotiable. Contact Harold Kaseff, Administrator, Richland Memorial Hospital, Olney, 62450. 618-395-2131. (12)

**PINCKNEYVILLE:** Population 3500—Serves an area of 20,000. Medical group partnership of four physicians seeking fifth member. Complete office facilities—2 Blocks from fully accredited hospital. Salary one year—then partnership. Good recreational facilities—near St. Louis. Contact: Clarence E. Cawvey, M.D., 206

North Main Street, Pinckneyville 62274 Phone: 618-357-2131. (2)

**QUINCY:** Emergency medicine opening—rural mid-western atmosphere—Centrally located for outdoor recreation. Modern 280-Bed Hospital and Trauma Center. 2 M.D.'s looking for a partner or part-time Physician. Guarantee inc. and excellent schedule very flexible. Call collect or write, Thomas Fischer, M.D., Blessing Hospital, Quincy, 62301 (217) 223-5811. (11)

**ROCHELLE:** Population 10,000—Two primary care physicians needed. Hospital serves an area of approximately 20,000. Acute general 68-bed hospital with full services, including physical and respiratory therapies. Office space available adjacent to hospital. Located 25 miles from Rockford and a medical college, 17 miles from major university, and an hour-and-a-half from Chicago. Excellent schools, parks and civic organizations. Contact Administrator, Rochelle Community Hospital, 900 North 2nd Street, Rochelle 61068 (815) 562-2181. (2)

**ROCKFORD:** OB-GYN, Board Eligible or Certified. Will support for Solo Practice or Associate. Practice base in Catholic Hospital. Contact: John E. Tillis, M.D., 5670 East State Street, Rockford, 61108, Phone: (815) 398-4110. (11)

**ROCKFORD:** Opening for Board eligible Internist in multi-specialty group of internists. Brand new building; two minutes from large, modern hospital. Near Rockford School of Medicine—part time teach opportunities if desired. Guaranteed income with full partnership after one year. 90 miles NW of Chicago on I-90. CONTACT: T. R. Glatter, M.D., 5670 E. State St., Rockford 61108. 815-398-4040 or 815-877-0096. (2)

**ROCK ISLAND:** Family practitioner, excellent guarantee and office arrangements. Send C.V. to Thomas J. Lavery, 2701-17th St., Rock Island, Illinois 61201 or call (309) 793-1000 (collect) for additional information. (1)

**WAYNE CITY:** Thriving community located in Wayne County in southern-most Illinois. Office facilities furnished for young Family or General Practitioner. No physicians in this community. Contact: Grant Smith, President, First National Bank, Wayne City 62895; 618/895-2118. (2)

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### Doctor's Job Fair

Illinois State Medical Society  
55 E. Monroe—#3510  
Chicago, IL 60603

Please send more information regarding the Doctor's Job Fair, December 5, 1976.

\_\_\_\_\_Include hotel reservation card.

(Please Print)

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

# CLASSIFIED ADVERTISING

## Positions & Practice Opportunities

**PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT** and Emergency Room. Become part of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801. Phone (217) 337-3239.

**OB-GYN, PEDIATRICS SPECIALISTS** needed by 16-man multispecialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., La Crosse Clinic, 212 South 11th Street, La Crosse, Wisconsin 54601.

**EXCELLENT OPPORTUNITY AND ENVIRONMENT**—Physician needed to practice general medicine in large outpatient clinic and 38 bed fully accredited hospital. Must possess empathy toward college age population. Salary negotiable, excellent fringe benefits. Contact L. W. Combs, M.D., Purdue Student Hospital, West Lafayette, IN 47907, 317-749-2441. Equal access/equal opportunity employer.

**UROLOGY:** Board eligible seeking position for solo, group, or assn. leading to partnership. Send reply to Illinois Medical Journal, Box 86B, 55 E. Monroe, Suite 3510, Chicago 60603. Or phone (312) 449-2377.

**RADIOLOGY:** Gen. Radiology residence completing Dec. 76. Seeking position for solo, group, or assn. leading to partnership. Send reply to Illinois Medical Journal, Box 86B, 55 E. Monroe, Suite 3510, Chicago 60603. Or phone (312) 449-2377.

**EMERGENCY MEDICINE:** Career opportunities available in E.D. medicine. Also short-term and locum tenens. Urban and rural Illinois, Missouri, Ohio and Colorado locations. Flexible work schedules, competitive remuneration. Paid malpractice, vacation, educational leave, interview expenses. Call Doctors Cooper or Spurgeon toll-free 1-800-325-3982 or send C.V. to Box 11241, St. Louis, Missouri 63105.

**OPEN-ENDED OPPORTUNITY FOR A GENERAL/FAMILY PRACTITIONER**, with or without surgical involvement. Full-time physician is needed, though part-time or "Locum tenens" may be considered. The community is rural, with a population of approximately 3,000, and a service area of 8-10,000, located 120 miles Southwest of Minneapolis. It has a diversified economic base, underpinned by some of the country's most productive agricultural land. It has a broad range of religious, service and social organizations. The community currently has three general practitioners, one of whom is semi-retired, averaging 60 years of age. It has two clinics, a 34-bed hospital, a 60-bed nursing home and two pharmacies. A surgeon and pathologists from Mankato and a radiologist from Albert Lea make regular trips to the community and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles). For additional information, contact D. H. Gilbert, Wells Municipal Hospital, 400-4th Avenue, S.W., Wells, Minnesota 56097. (507) 553-3111 or 553-5904.

**FAMILY PRACTITIONER WISHES ASSOCIATE** who is Board certified or Board eligible in family practice to join family practice. Located in Waterloo, Iowa, a northeast Iowa community of 75,000. All records dictated on the Problem Oriented Medical Records System. Ronald R. Roth, M.D., 611 Black's Bldg., Waterloo, Iowa 50703.

**NEONATOLOGIST** to join 9 member Pediatrics Division of a 90 doctor multi-specialty clinic with adjacent hospital; located in Big 10 University community of 100,000; large referral practice, as well as primary care; new medical school offers opportunity for teaching; hospital has just under 1000 deliveries per year with 13,000 per year in area without designated center; OB/Pediatrics Departments are requesting state designation as perinatal center with completion in early 1977 of excellent new hospital, L & D, NICU facilities. Contact Medical Director, Carle Clinic, Urbana 61801.

**PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT** and Emergency Room. Become part of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana 61801, (217) 337-3239.

**BOLINGBROOK**—population 30,000, drawing area 70,000. Growing at a rate of 4,000 people a year. Four M.D.'s established in the community. Urgent need for additional M.D.'s in all fields, particularly, OB and Peds. Associate or solo available. Send resume to: Manager, Bolingbrook Professional Building, 519 E. Briarcliff Road, Bolingbrook, Illinois 60439; (312) 739-5121.

**PEDIATRIC NEUROLOGIST** to join 9 member Pediatrics Division of a 90 doctor multispecialty clinic with adjacent hospital; located in Big 10 University community of 100,000; large referral practice, as well as primary care. New medical school offers opportunity for teaching; clinic has 3 member Neurology Department and active neurosurgical program, an EMI scanner and potential for limitless growth in neurosciences. Contact Medical Director, Carle Clinic, Urbana 61801.

**OB-GYN, UROLOGY, AND ORTHOPEDIC** specialties to join an established successful practice with 15-man multi-specialty group. Excellent group benefits; retirement plan; modern clinic facilities; progressive community with excellent educational system including two colleges; area population 75,000; great recreational facilities; must be board eligible or certified; Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

**INTERNIST**—with special interest in Cardiology. Good E.K.G. volume—exclusive interpretation privilege. Charming town in center of Southern Illinois vacation area; many lakes and parks. Diversified industrial base. Contact—Larry Feil, Administrator, Herrin Hospital, 201 S. 14th Street, Herrin, Illinois 62948—telephone collect 618-942-4710.

**TWO FAMILY PHYSICIANS** with large hospital practice wish third associate who is Board Eligible, to join busy family practice. Located in Waterloo, Iowa, a northeast Iowa community of 75,000. All records dictated on the Problem Oriented Medical Records Systems. Ronald R. Roth, M.D. & Ronald D. Flory, M.D., 611 Black's Bldg., Waterloo, Iowa 50703.

**We are looking for an energetic Surgeon with General Practice experience** to join our staff and practice principally with the Physician who founded our Medical Center 47 years ago. We have a 27 room clinic located in a stable neighborhood just South-west of downtown Chicago. Complete facilities include X-Ray, Laboratory, Physical-Therapy, Pharmacy and minor-surgery room. The practice is primarily private patient with some industrial accounts. The right individual can expect partnership within 6 months to 1 year, with the opportunity to ultimately assume the practice. If interested, please call AC312-523-1043.

**PERSONNEL WANTED**—Internist needed for part-time position of medical consultant, HEW, SSA-Bureau of Disability Insurance. Flexibility of working hours offered. Submit Curriculum Vitae to: Bureau of Disability Insurance, 300 South Wacker Drive, Chicago 60606. **ATTENTION:** Dr. Talmage G. Hiebert, Regional Medical Advisor. (312) 353-7117

**FAMILY PRACTICE POSITION** for one or two physicians. Satellite expansion to nearby smaller town in Southern Wisconsin provides excellent opportunity of enjoyable living. Administrative, retirement, technical and time-off coverage of a large group. No investment. Weekend coverage. Contact Frank C. Stiles, M.D., The Monroe Clinic, Monroe, Wis. 53566 or call (608) 328-7000.

**FAMILY PHYSICIAN**—unmatched opportunity to head up new primary care center in attractive Chicago suburb. No investment requirement. Guaranteed income and benefits. Early partnership. Limited call. Excellent specialty back up. No management headaches, unless desired. Will tailor practice responsibilities to individual needs. Reply Box #B69 c/o IMJ, Suite 3510, 55 E. Monroe, Chicago, 60603.

**UNIQUE OPPORTUNITY FOR A PEDIATRICIAN** to practice part time ambulatory pediatrics in a modern office 40 miles from Chicago. Salary and hours to be mutually agreed upon. For further information write, Box 870, IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**Physicians, Southeast Missouri.** Needed Immediately. Excellent opportunity, salary open for discussion. Call COLLECT 314-785-7701 ext. 61.

**FAMILY PRACTICE, INTERNAL MEDICINE, OBSTETRICS-GYNECOLOGY** The above physicians wanted to join an expanding, multispecialty group in Southwestern Michigan. Clinic is located next to an 89 bed general hospital, with excellent staff and equipment, provide high quality medical care. All members of the group are board certified or eligible. Excellent fringe benefits and starting salary. Please write or call: Gary Piippo, Administrator Allegan Medical Clinic, P.C., 551 Linn St., Allegan, Michigan 49010. Phone: Area Code 616-673-B402.

**ILLINOIS—EMERGENCY PHYSICIANS WANTED. EARN UP TO \$7B,000** per annum in low volume or busy ER's. Work two days, off five, earn \$50-\$60,000. Work only 26 weeks, earn \$50-60,000. For further information write BOX NUMBER 871, IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

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**SINGLE OFFICE OR SUITE AVAILABLE**, with large reception area, and parking, one block off Edens expressway in Highland Park. Newly decorated, air-conditioned, fully carpeted and furnished in modern professional building with electronic security. Building maintenance includes evening and week-end use. Call OR 5-3057 or B31-5060.

**BUY OR RENT AN 800 SQ. FT. SUITE**, luxuriously finished and absolutely independent in a recently completed 13 Suite Professional Center in Barrington, Ill. A desirable place to practice and to live. Ample paved parking and just a few blocks from the recently approved 166 Bed Good Shepherd Hospital. Inquire now while the selection is good. Excellent terms. Write to Box 866, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago Ill. 60603.



Blue Cross®  
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# REPORT

## FOR *Illinois Physicians*

### Improved Coverage for GTE Automatic Electric Employees

Employees of GTE Automatic Electric, Inc. and their eligible dependents have improved health care protection under a Blue Cross-Blue Shield contract that provides higher benefit payments for medical expenses. An important addition to their program includes payment to physicians at 100% Usual and Customary for outpatient diagnostic services.

The contract is effective September 1, 1976 for Northlake, Illinois employees (Group 1553) and October 1, 1976 for employees in the Genoa, Illinois area (Group 1554).

The outpatient diagnostic portion of the contract covers X-rays, pathology and laboratory services, including electrocardiograms, electroencephalograms, basal metabolism rate and radioisotope tests, when such services are directed toward the diagnosis of a definite condition of disease or injury and are provided by a Blue Cross Plan hospital or licensed physician.

Blue Cross pays the full amount of the hospital's regular outpatient diagnostic test charge, and the Blue Shield payment is 100% Usual and Customary for each diagnostic test covered under the contract, exclusive of the charge for the office visit.

Standard exclusions apply, such as routine physical examinations, diagnostic examinations in connection with pregnancy, routine Pap tests, determination of refractive errors of the eyes, surveys, case finding programs, research studies, screening or similar procedures and studies.

Some of the key benefits paid on a schedule of allowances include:

- *Physicians' services* wherever they are performed—hospital, outpatient, doctor's office or elsewhere—up to \$800 per procedure for surgical services performed by a licensed physician and for the specialized services of a licensed dentist or podiatrist when such services are common to medicine, dentistry or podiatry and fall within the scope of the licensure of the dentist or podiatrist.

- *Assistant surgeon*—20% of scheduled surgical allowance for fee of assistant surgeon. Benefits available when technical surgical assistance is medically necessary and no house staff is available.

- *Anesthesiologist's fee* (if other than the surgeon or his assistant). Program pays 20% of surgical or obstetrical allowance, with a minimum of \$20.

- *Emergency treatment* within 72 hours after an accident or onset of a sudden and serious illness up to a maximum of \$20 for initial visit.

- *X-rays, laboratory and pathology services*—provided they are consistent with the illness or diag-

nosis for minor surgery, emergency treatment and/or a medical emergency, but excluding routine physical, pregnancy examination and Pap tests.

- *Consultation in hospital*—program pays for one consultation per admission as a hospital bed patient or in an Extended Care Facility by a specialist. Allowances are as follows: limited consultation \$25; complete history and diagnostic examination \$40.

- *Shock treatments*—\$20 per electric and \$10 per insulin shock treatment up to a maximum of \$140 for each type per calendar year, when received as hospital bed patient.

- *Radiation therapy*—benefits for treatment of cancerous conditions by x-ray, radium, radon, and radioisotope therapy with a maximum per calendar year of \$200 for treatment of superficial cancer, and to \$400 per calendar year for treatment including cobalt, of deep cancer. Maximum benefit for all radiation treatments per calendar year is \$400.

- *Hemodialysis*—when administered to a hospital bed patient, for treatment of acute kidney failure, allowance for this service is \$115. Fee for cannula insertion is included in this allowance.

- *Dental surgery*—benefits paid for hospital charges and surgeon's fee on surgical schedule when procedures are performed as direct result of an accidental injury or for removal of impacted teeth, or when a physician certifies that hospitalization is required to safeguard health of patient because of the presence of a serious medical condition.

- *Medical care in hospital*—120 inpatient medical visits at \$10 per visit for first five daily visits and \$8 per visit for remaining 115 daily visits per illness or injury.

- *Intensive care*—\$115 maximum during critical care period for such conditions as acute heart failure, diabetic coma or massive bleeding of a vital organ.

- *Maternity benefits*—upon completion of 270 days membership in Family Plan, full semi-private hospital benefits are paid up to 120 days, with \$225 physician's charges for prenatal, normal delivery and postnatal care; \$350 Cesarean section; \$25 circumcision (newborn). Routine hospital care is in benefit during period of normal confinement for newborn infant. Program also provides extended coverage up to 120 days for semi-private hospital care if child is premature, ill or otherwise incapacitated. Schedule of physician's charges are paid if child is premature or requires extended hospital care because of illness or congenital defect.

### New Billing Procedure For Reassigned Groups

Reimbursement may be made under the Medicare program on assigned claims to someone other than the physician who performed the services, under the following conditions:

1. To the employer of the physician who provided the service; if that physician is required to turn over his fee to his employer as a condition of his employment. The employer, facility, or organization must have an employer identification number and must issue W-2 forms to the individual physicians. Each physician must have a Social Security number and an Illinois license to practice medicine. There must be a written contract with each physician stating that the employer has the right to accept payment for the physician's services.
2. To a facility in which the service is provided, if there is a contractual arrangement between the physician and the facility whereby the facility bills for the service.
3. To a foundation, plan, or similar organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between the physician and the organization whereby the organization bills for the service.

New instructions issued by the Department of Health, Education and Welfare state that whether the group uses a uniform fee schedule or an individual fee schedule, the Medicare Carrier must accumulate individual data on each physician.

*Each Medicare claim submitted by a reassigned group must, therefore, have the name of the physician who actually rendered the service in item 14 on the Medicare form. Each claim must also include the physician's specialty. The specialty may be written on the label\* in item 8, or at the bottom of the item 7-C column.*

Physicians are also encouraged to provide this information on their bills to beneficiaries when assignment is not accepted and patients submit the bills themselves.

\*Medicare labels for use in item 8 may be obtained from:

The Provider Update Unit  
Medicare Part B  
P.O. Box 2218  
Chicago, Illinois 60690

### Submission of Claims by Billing Services

A new ruling by the Department of Health, Education and Welfare emphasizes that when a billing service completes Item 14 of the SSA-1490 Medicare form by signing the name of the physician on the claim, it must also give the name of the person authorized to sign for the physician, his title, and name and address of the billing service. For example:

"F. W. Newton, M.D., by Vincent White, Assistant Director, Cook Billing Service, 500 East Water Street, Chicago, Illinois."

A stamp may be used to supply this information. Medicare payment, however, may be made only to the physician who furnished the service.

The date of signature should also be entered to indicate that the claim was filed within proper time limits for payment. Claims must be filed by December 31, 1976 for services furnished in the current year, during the preceding year, and for the last 3 months of the prior year. For example: For services performed between October 1, 1973 and September 30, 1974, claims must have been filed by December 31, 1975. For services performed between October 1, 1974 and September 30, 1975, claims must be filed by December 31, 1976.

### SSA Changes in Lab Certification

Notice was received from the Bureau of Health Insurance Office, Social Security Administration of the following changes in participation or certification status of laboratories in the Medicare program:

#### Reinstated in the Medicare program:

Sommerfield Medical Laboratory, Inc.  
5815 Dempster Street  
Morton Grove, Illinois 60053  
Provider Number: 14-8067  
Effective Date: September 22, 1976

The laboratory is approved by the Illinois Department of Public Health to perform procedures in Hematology and EKG Services.

The following laboratories are closed and no payment can be made under the insurance program for services rendered after the effective closing dates:

Westlawn Medical Laboratory, Inc.  
4255 West 63rd Street  
Chicago, Illinois 60629  
Provider Number: 14-8240  
Effective Date: September 11, 1976

Ridgeland Medical Laboratory  
101 Madison Street  
Oak Park, Illinois 60302  
Provider Number: 14-8254  
Effective Date: August 30, 1976



# If your angina patient\* isn't having 3 out of 4 better days than usual... try Cardilate® (ERYTHRITYL TETRANITRATE)

\*Please note: unstable angina patients may be refractory to all long-acting nitrates

**INDICATIONS:** For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

**PRECAUTIONS:** As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

**SIDE EFFECTS:** No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

**SUPPLIED:** 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

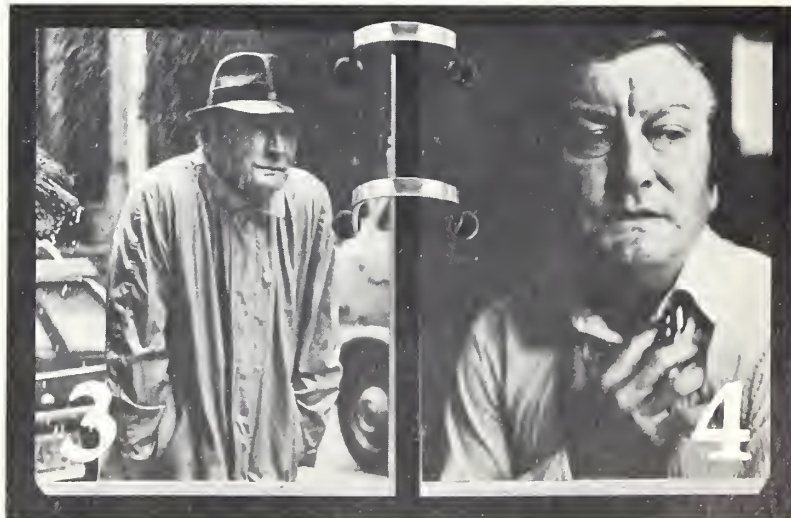
Also available: Cardilate®P brand Erythryl Tetranitrate with Phenobarbital\* (\*Warning: may be habit-forming).

1. Russek HI: AM J M Sc 239:478, 1960



**"Pain days" significantly reduced with Cardilate®** (erythryl tetranitrate) in 48-patient study.<sup>1</sup> Patients on placebo experienced same pain as usual or increased pain 2 days out of 3...compared to 1 day out of 4 while on Cardilate.

**Rapid-acting chewable tablets** (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.



**Effective prophylaxis against attacks;** increases exercise tolerance. Serious side effects have not been reported in 20 years' clinical use.

**Cardilate can save patients money;** is less expensive than many popular long-acting nitrates. 20% to 30% savings not uncommon...also helps reduce need for nitroglycerin.



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Research Triangle Park  
North Carolina 27709

# Editorials



## ***RETIREMENT***

A major decision for older physicians concerns retirement planning. The idea of "dying with your boots on" is passe, and physicians are tired of government red tape, malpractice suits, and the threat of recertification or relicensure. In addition, some find it increasingly difficult to keep up with medical progress and to take the never ending criticism.

No one can predict whether they will enjoy retirement, or how they will spend the free hours every month, but planning ahead definitely helps. The major decision is whether to retire at home or to move to a more equable climate. The doctor may prefer to live near family and friends, although remaining at home presents problems to the physician. It is not easy to shut off the flow of patients.

Moving to a more equable climate has many advantages. Separation from friends and familiar surroundings does not lead to as much difficulty as one might think. Wherever you go there are nice people, and senior citizens are growing in numbers and becoming a potent minority. The retiree usually finds time for golfing, boating, gardening, traveling, or working on part time projects. There are no commitments, waiting responsibilities or deadlines. Expenses are minimal and one lives life as he wants.

Retired physicians are reaping the benefits of the "good life" they helped to create. Medical progress has brought a tremendous increase in our life span. Many are eligible for social security and/or the equivalent of a pension by taking advantage of laws providing the opportunity to build retirement income. With this additional security the doctor can now look forward to more happiness in his later years.

The best asset, however, is a more fundamental one than environment, entertainment or financial security. The most valued asset for a retired physician is the one to which he has devoted a lifetime. In the final analysis, the greatest prerequisite to a peaceful retirement is good health.

T. R. Van Dellen, M.D., *Editor*



## NATIONAL HEALTH INSURANCE

### The Administrative Question

One of the great outcries of the day is that privately oriented health care is not economical and systematic enough and that the federal government should spring to the rescue, a la Rin Tin Tin. But how deft is the government (notably the Social Security Administration) in cost management? How qualified is it to administer any program of National Health Insurance? How blameless is it for the expense of Medicare?

Negative answers can be inferred from a recently released study of Medicare Part A cost performance. What makes the study especially noteworthy is its source: the General Accounting Office (GAO), a federal agency.

GAO compared SSA's performance with that of four private insurance companies in dealing with institutional providers of Medicare services.

The average cost—excluding audit—of a bill processed by SSA's Division of Direct Reimbursement (DDR) was \$12.39 in 1973, compared with \$7.31 for Travelers, \$7.28 for Mutual of Omaha, \$3.81 for Blue Cross of Chicago, and \$3.55 for Blue Cross of Maryland. The lower costs for the "Blues" were attributed partly to their smaller, more wieldy territories.

However, GAO found that "higher salaries and lower productivity appear to be major reasons for the higher costs of the Division (DDR), which, unlike the private intermediaries, had no production standards."

DDR's annual compensation exceeded that of neighboring Maryland Blue Cross by 25% for accountants and auditors, 51% for claims examiners.

"Despite DDR's higher costs," the report continued, "it generally took longer than other intermediaries to pay bills and settle with providers. Its error rate was average."

Adding to the weight of the findings is the nonpolitical, independent character of the General Accounting Office. It is the fiscal watchdog of Congress, though its head (the Comptroller General) is appointed by the President. Its Medicare report was a detailed response to questions put to it by the House Ways and Means Committee chairman.

All of this should be borne in mind in weighing the rebuttals from the Department of Health, Education, and Welfare—and from Max W. Fine, executive director of the Committee for National Health Insurance and prolific writer of sly "letters to the editor" of newspapers.

HEW—and Fine—call the report outdated. But DDR's lack of cost data (GAO had to develop them) could help the delay.

HEW contends that its costs per bill are overstated for 1973 since bills processed through magnetic tape are excluded. HEW also maintains that costs have dropped since 1973, though this is also true for other carriers in the study. GAO said it has not verified the new figures.

So the burden of proof hangs heavy on the Social Security Administration. Meanwhile, Congress ought to think hard about the report from its fiscal watchdog. And think hard about making SSA the health-insurance administrator for the public at large, as proposed in such legislation as the Kennedy bill.

American Medical Association

consider the effect on  
coexisting diabetes when  
you prescribe a vasodilator\*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the  
diabetic patient has been reported with

# VASODILAN®

(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

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\*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.



## Obituaries

\***Henry E. Bielinski**, Chicago, died September 10th at the age of 68. Doctor Bielinski was a 1937 graduate of the Loyola University Stritch School of Medicine. He was also a past president of the Polish Medical Society of Chicago.

\***George R. Chobot**, Berwyn, died September 6th at the age of 63. Doctor Chobot was a 1941 graduate of the University of Illinois.

\***Mirta Goffan, M.D., D.D.S., Ph.D.**, Chicago, died August 31st at the age of 34. Doctor Goffan was a 1963 graduate in dental surgery from the University of Buenos Aires. She received her Ph.D. in Immunology from the University of Illinois Medical Center in 1973, and her M.D. from Rush Medical School in 1974. Doctor Goffan was an immunologist and a teaching assistant in biochemistry at the University of Illinois Medical Center.

\***Fritz Koenig**, Danville, died September 8th at the age of 67. Doctor Koenig was a 1933 graduate of the University of Vienna. He was also a past president of the Vermilion County Medical Society.

\***Michael Rainiero**, Chicago, died September 17th at the age of 63. Doctor Rainiero was a 1940 graduate of the University of Naples. He was also emergency room director at Northwest Hospital from 1966 through June, 1976.

\*\***Antony S. Sampolinski**, Chicago, died August 28th at the age of 86. Doctor Sampolinski was a 1919 graduate of the Loyola University Stritch School of Medicine. He was a faculty member at both the Loyola University Medical School and the Cook County Graduate School of Medicine, as well as a staff member at St. Mary of Nazareth, Resurrection and Cook County Hospitals.

\***Richard Sternheimer**, Chicago, died September 13th at the age of 76. Doctor Sternheimer received his medical degree in Berlin, Germany, in 1925.

••Indicates ISMS member of the Fifty Year Club  
•Indicates ISMS member

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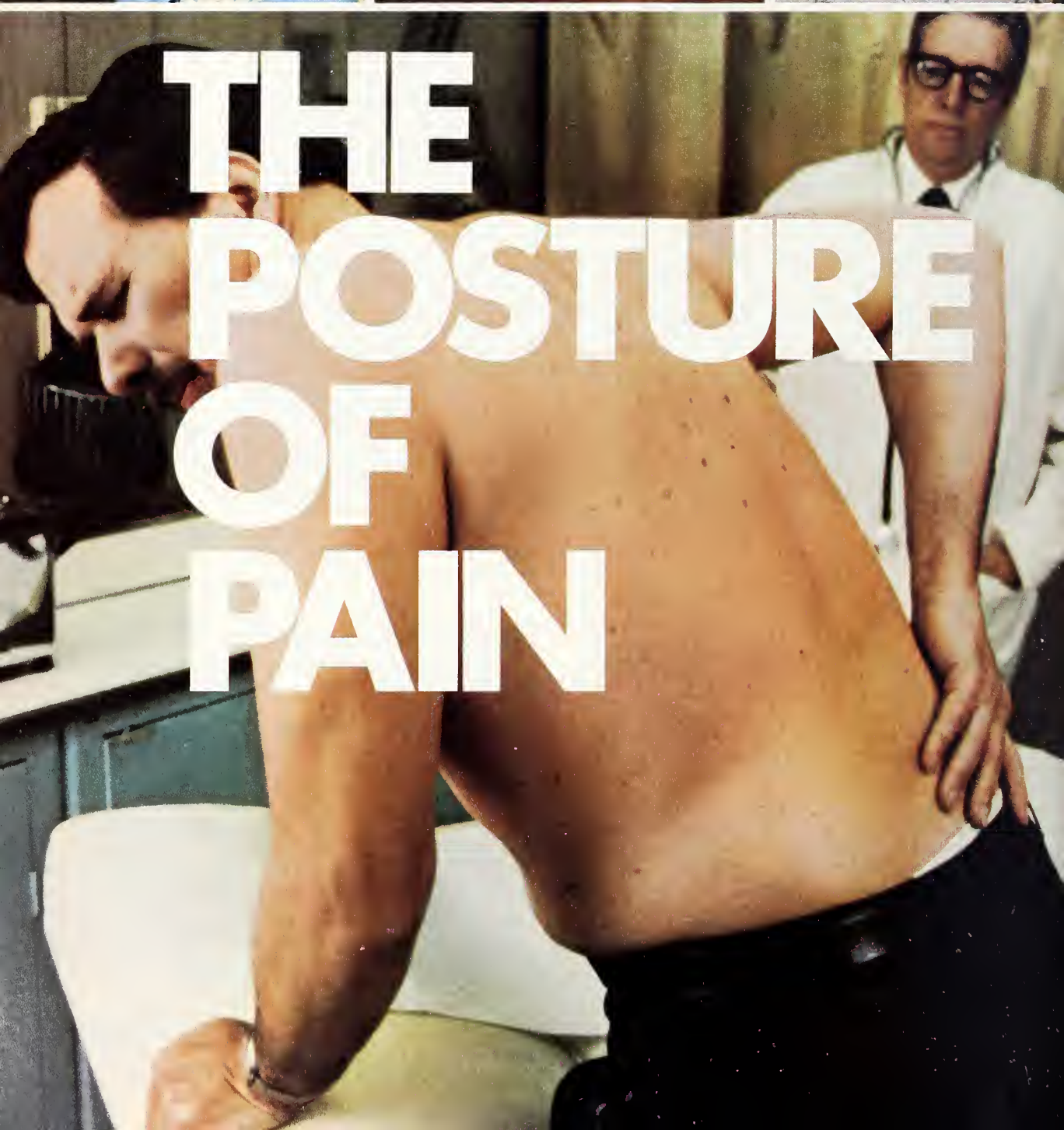
## Clinics for Crippled Children Listed for December

Twenty eight clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will count nineteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be seven special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

December	1	Rock Island Cerebral Palsy, Foundation for Crippled Children and Adults
December	1	Hinsdale, Hinsdale Sanitarium
December	2	Sterling, Community General Hospital
December	2	Litchfield, St. Francis Hospital
December	2	West Frankfort, Union Hospital
December	2	Lake County Cardiac, Victory Memorial Hospital
December	7	Rock Island, Moline Public Hospital
December	8	Rockford, St. Anthony Hospital
December	8	Champaign-Urbana, McKinley Hospital
December	9	Springfield, St. John's Hospital
December	9	Kankakee, St. Mary's Hospital
December	10	Chicago Heights Cardiac, St. James Hospital
December	10	Division Cardiac, U. of Illinois Hospital, Center for Handicapped Children
December	13	Peoria Cardiac, St. Francis Children's Hospital

December	14	Peoria, St. Francis Children's Hospital
December	14	Belleville, St. Elizabeth's Hospital
December	14	Carmi, Carmi Township Hospital
December	15	Springfield Pediatric-Neurology, St. John's Hospital
December	15	Aurora, St. Joseph Mercy Hospital
December	15	Chicago Heights, St. James Hospital
December	16	Rockford Memorial Hospital
December	16	Elmhurst Cardiac, Memorial Hospital of DuPage County
December	16	Bloomington, Mennonite Hospital
December	17	Chicago Heights Cardiac-St. James Hospital
December	17	Evanston, St. Francis Hospital
December	20	Peoria Cardiac, St. Francis Children's Hospital
December	21	Peoria, St. Francis Children's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital School, civic and fraternal clubs, visiting nurse association, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on behalf of crippled children.



# THE POSTURE OF PAIN



# but she may not have the stomach for APC.

Or the kidneys, for that matter.

Even bleeding time and platelet aggregation can be maximally prolonged by a single aspirin tablet.\*

We took that into account in revising the formula of Phenaphen® with Codeine, and combined codeine (in any of three different strengths) with acetaminophen to complement the codeine with little risk of APC complications. While there's no anti-inflammatory activity, there's no aspirin to aggravate G.I. problems or adversely affect bleeding time. Similarly, there's no potential renal risk from phenacetin, and no caffeine to stimulate patients unnecessarily.

There is the convenience of telephone Rx under Federal law...and the complementary analgesic efficacy of acetaminophen.

Phenaphen® with Codeine. Not just for patients who might have a "compound" problem, but for almost every patient who needs codeine. It's a lot simpler than APC.

## BRIEF SUMMARY

**Contraindications:** Hypersensitivity to acetaminophen or codeine.

**Warnings:** *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

*Usage in ambulatory patients.* Caution patients that acetaminophen and codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

*Interaction with other CNS depressants.* Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

*Usage in Pregnancy.* Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

**Precautions:** *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

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*Special risk patients.* Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

**Adverse Reactions:** Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

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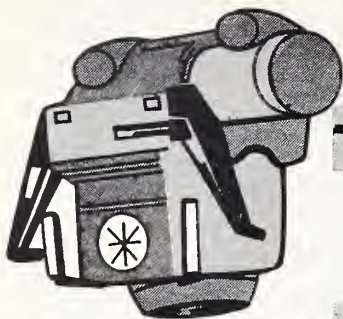
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\*Mielke, C.H., et al.: JAMA  
235:613 (Feb. 9) 1976.

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## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

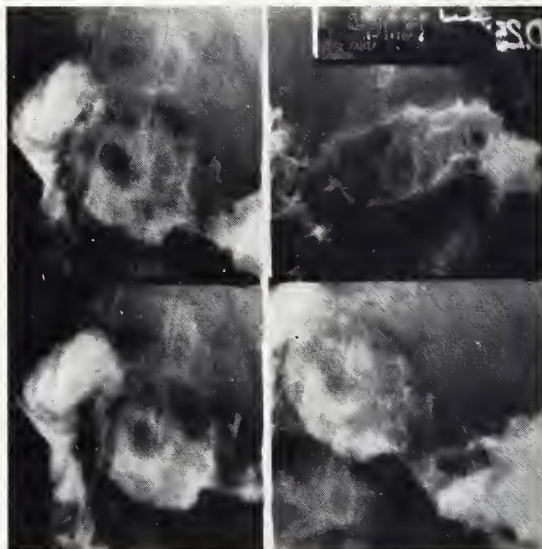
This patient was a 21-year-old mental defective who had entered the hospital because of persistent vomiting and abdominal pain. An upper GI series was done and was followed by a gastroscopic examination which revealed multiple small ulcerations with hemorrhagic areas involving the lower third of the stomach and extending into the duodenal bulb.



**Figure 1**



**Figure 2**



**Figure 3**

What's your diagnosis?

1. Antral Gastritis with superficial ulcers
2. Eosinophilic Gastroenteritis
3. Syphilis of the stomach
4. Crohn's disease

*(Answers on page 513)*



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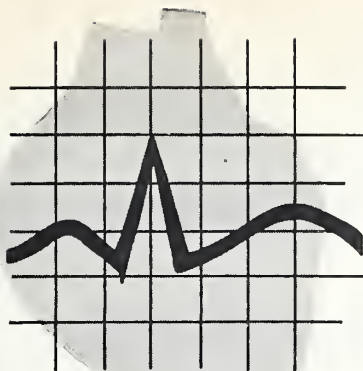
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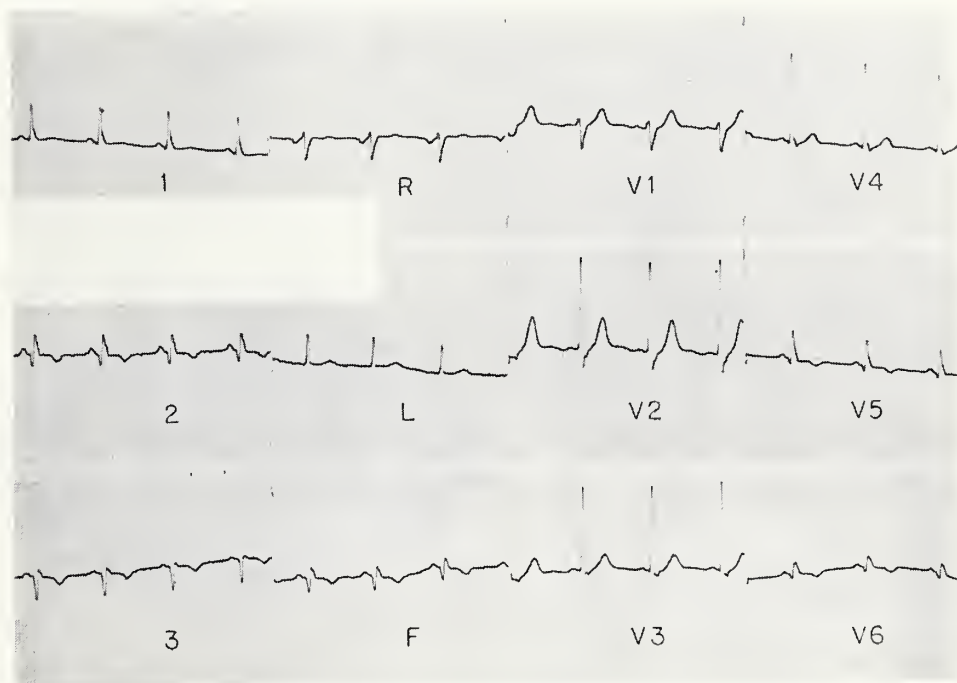




## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RINGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

A forty-six year old man presented to the emergency room with a four hour history of chest pressure. He believed it was gradually worsening and seemed to make him nauseated. Physical examination demonstrated an acutely ill man who was diaphoretic. Blood pressure was 110/70 mmHg and pulse rate was 75/minute. An atrial gallop could be heard but there were no murmurs. A portable chest X-ray was normal. This ECG was taken.



### Questions:

#### 1. The ECG shows:

- A. Sinus rhythm.
- B. A recent inferolateral wall myocardial infarction.
- C. Right ventricular hypertrophy.
- D. A probable true posterior or dorsal wall myocardial infarction.
- E. Left axis deviation, probable left anterior hemiblock.

#### 2. Treatment includes:

- A. Admission to the coronary care unit.
- B. Adequate relief of pain with meperidine 75-100 mg intramuscularly.
- C. ECG monitoring.
- D. Serial serum enzymes CPK, SGOT and LDH.
- E. All of the above.

(Answers on page 526)

# Because irritable bowel syndrome\* is a psychovisceral problem...



The symptoms of irritable bowel syndrome have long been recognized as functional concomitants of excessive anxiety and emotional tension. Relationships between emotionally charged life situations and disorders of colonic motility have even been demonstrated by means of stress-interview experiments.<sup>1</sup> And disturbed bowel function is often induced or aggravated by fluctuating psychologic states rather than organic disease.

After the patient history has been reviewed and organic disease excluded, the patient should be reassured as to the nature of his condition and treatment directed toward both the somatic and emotional aspects of the disorder. Adjunctive therapy with Librax is doubly valuable because it reduces not only painful symptoms due to colonic hypermotility but also underlying excessive anxiety and emotional tension.

<sup>1</sup>Almy TP: Irritable colon, chap. 100, in *Gastrointestinal Disease*, edited by Sleisenger MH, Fordtran JS. Philadelphia, W.B. Saunders Company, 1973, pp. 1281-1283.





# IMJ

Illinois Medical Journal

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## Pulmonary Atresia with Ventricular Septal Defect in Three Relatively Asymptomatic Children

BY B. AGARWALA, M.D.; R. AGARWALA, M.D.; F. CUCHER, M.D.;  
AND T. BAFFES, M.D./CHICAGO

*Three children with pulmonary atresia and ventricular septal defect are presented. In the absence of cyanosis, and the presence of a loud continuous murmur and increased peripheral pulse pressure, a preliminary diagnosis of persistent ductus arteriosus might reasonably be suspected in these children. Upon further investigation, however, all were found to have pulmonary atresia, VSD, and patent ductus arteriosus. One patient had in addition a tricuspid stenosis. The clinical presentation, hemodynamics and the surgical management of this combination of anomalies is discussed. Finally, the hemodynamic importance of the patent ductus arteriosus in these three children to keep them relatively asymptomatic has been discussed.*

Pulmonary atresia with ventricular septal defect (VSD) is generally considered to be the most severe form of tetralogy of Fallot. It may not be as rare a variant as previously believed.<sup>1</sup> Patients with pulmonary atresia and VSD frequently present with severe hypoxia, intense cyanosis and often metabolic acidosis in the first few days of life.<sup>2</sup> In the absence of a direct communication between the right ventricle and the lungs, the pulmonary circulation is often maintained, at least in the first few postpartum days, via the patent ductus arteriosus (PDA) and the bronchial arteries. If the PDA closes, as it commonly does, the bronchial collateral circulation is usually inadequate to sustain the life of the infant and death rapidly ensues.<sup>1</sup> Occasionally prolonged survival may result from the development

of enlarged bronchial arteries arising from the aorta and providing adequate pulmonary perfusion.<sup>3</sup> Less commonly, a persistent ductus arteriosus may provide the pulmonary blood flow.<sup>4</sup> Even with the development of collateral circulation to the lungs, however, the clinical picture is generally dominated by symptoms of diminished pulmonary blood flow and cyanosis.

The three children described here (two aged five, and one nine years old) were basically asymptomatic and acyanotic for most of their lives and could easily have been diagnosed as having a PDA until admission for cardiac evaluation. The reasons these children tolerated their heart disease so well through childhood are related to the hemodynamics.

## Case History One

A five year old girl was born in Greece, the product of a normal full term pregnancy and delivery. Transient cyanosis was noted at birth but disappeared at two days of age. Mild cyanosis reappeared just prior to her recent admission for cardiac evaluation. According to her father, she became only slightly cyanotic with moderate exertion. She was otherwise asymptomatic. Parents denied a history of squatting, cyanotic spells, episodes of pneumonia or frequent colds. No family history of congenital heart disease was present.

### Physical Examination

Physical Examination revealed a well developed, well nourished, somewhat anxious five year old female in no acute distress. Weight and height on admission were 17 kilograms and 118 centimeters respectively. The vital signs were as follows: respiratory rate 22/minute; heart rate 112/minute; blood pressure 110/70 mm of Hg and rectal temperature 98.5°F. Her lips appeared dusky in color. Both lungs were clear on auscultation. The abdomen was soft on palpation and the liver was palpable 0.5 cm below the costal margin at the right mid-clavicular line. Mild cyanosis and clubbing of the nail beds were noted. The peripheral pulses were normal. The precordial maximal impulse was located on the 5th left intercostal space just outside the mid-clavicular line. A faint parasternal heave was felt. No thrill was detected. The first heart sound was normal, and the second heart sound was loud and single. A grade 2/6 continuous murmur was heard under the left clavicle. An ejection systolic click was noted at the base.

Chest X-ray revealed the cardiothoracic ratio of 11:18 with a prominent right atrium. The retrocardiac space was diminished suggesting left ventricular enlargement. Pulmonary vasculature was normal. The ascending aorta was slightly prominent.

The electrocardiogram showed a mean QRS frontal axis of +180 degrees with right atrial and biventricular hypertrophy. The hemoglobin and the hematocrit were 17 gm % and 51% respectively.

### Cardiac Catheterization

On cardiac catheterization the oxygen saturation of the aortic blood was 92%. The venous catheter could not be advanced into the pul-

monary artery from the right ventricle but slipped easily through the ventricular septal defect into the ascending aorta. Pull back pressure tracings revealed a significant end-diastolic pressure gradient across the tricuspid valve suggesting a mild degree of tricuspid stenosis. Right ventricular peak systolic pressure was exactly the same as that of the ascending aorta. Right ventricular angiogram demonstrated the blind pouch at the site of the outflow tract; the ascending aorta with its brachiocephalic branches were opacified from the right ventricle through the ventricular septal defect. The aortogram at the beginning of the descending thoracic aorta showed the presence of a large patent ductus arteriosus shunting blood into the pulmonary artery. The pulmonary artery could not be entered. The pulmonary venous wedge pressure was obtained by the venous catheter which entered the left atrium from the right atrium through the patent foramen ovale.

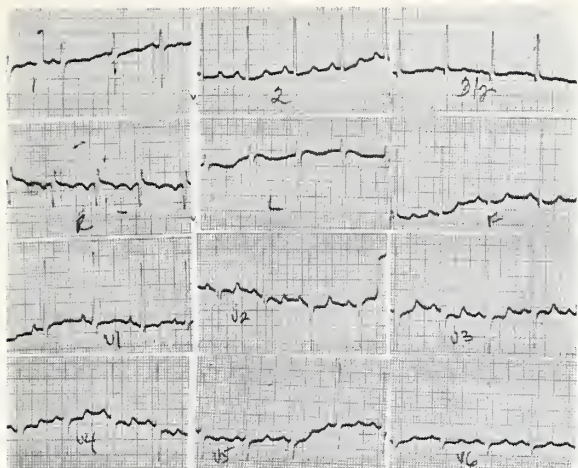
## Case History Two

A nine year old white girl, born after a normal full term pregnancy and delivery, was referred to us because of a heart murmur which was heard a week prior to admission. Upon questioning the parent we learned that the child occasionally became tired and her color pale and dusky with moderate exertion. No cyanotic spells or squatting were reported.

### Physical Examination

Physical Examination revealed a well developed, well nourished active girl in no acute distress. She weighed 28 kilograms, her height was 130 centimeters. Heart rate and the respiratory rate were 82/minute and 28/minute respectively. Blood pressure measured 120/65 mm Hg and the rectal temperature was 98°F. Her lips appeared cyanotic. The lungs were clear on auscultation. The abdomen was soft on palpation. Peripheral pulses were slightly increased. The precordial maximal impulse was noted in the 5th left intercostal space on mid-clavicular line. A faint parasternal heave and a faint systolic thrill were felt over the upper left sternal border. First heart sound was loud. The second heart sound was loud and single. A grade 4/6 continuous murmur was best heard under the left clavicle with wide radiation over the precordium. Another grade 2/6 ejection systolic murmur was heard along the left sternal border.





**Figure 1.** Electrocardiogram of Case 2. Note evidences of right axis deviation and right ventricular hypertrophy. Tall R wave in  $V_5$  and  $V_6$  may suggest biventricular hypertrophy.

An ejection systolic click was noted at the upper left sternal border.

On chest X-ray the cardiothoracic ratio was 12:19 and the apex was rounded and elevated with a prominent right atrium. Pulmonary vasculature was normal and the ascending aorta was prominent. The electrocardiogram revealed a mean QRS frontal axis of  $+135$  degrees with severe right ventricular hypertrophy (Fig. 1). Hemoglobin was 16.4 gm % with hematocrit of 46%.

### Cardiac Catheterization

During cardiac catheterization the oxygen saturation of the femoral arterial blood was 87.1%. The venous catheter could not be advanced into the pulmonary artery from the right ventricle but it entered easily through the ventricular septal defect into the ascending aorta. Right ventricular peak systolic pressure was exactly the same as that of the ascending aorta. Right ventricular angiogram demonstrated the blind pouch (Fig. 2) at the site of the outflow tract. The ascending aorta was opacified from the right ventricle through the ventricular septal defect. The aortogram at the arch of the aorta showed the presence of a large patent ductus arteriosus shunting blood into the pulmonary artery (Fig. 3). The pulmonary artery was entered from the descending thoracic aorta through the patent ductus arteriosus by a flow directed balloon catheter. The pulmonary arterial pressure was normal.

An anastomosis between superior vena cava and the right pulmonary artery (Glenn proce-



**Figure 2.** (Case 2) Contrast material is injected into the right ventricle in the P-A projection simultaneous filling of an atretic infundibular area (as shown by an arrow) and the aorta is seen.

dure) was performed. The post-operative course was uncomplicated.

### Case History Three

A five year old boy born in Greece was the product of a normal full term pregnancy and a caesarean section delivery. His birth weight was 3 kilograms. A heart murmur was noted at 3 months of age. Lately he became cyanotic with exertion and tired easily. Therefore, he was referred to us for cardiac evaluation. Historically, he never had a cyanotic spell but used to squat occasionally.



**Figure 3.** (Case 2) The venous catheter entered the aorta from the right ventricle through the ventricular septal defect. Contrast material is injected into the proximal part of the descending thoracic aorta in left anterior oblique position, it shows filling of the right and left pulmonary arteries via the huge patent ductus arteriosus (as shown by arrow).

## Physical Examination

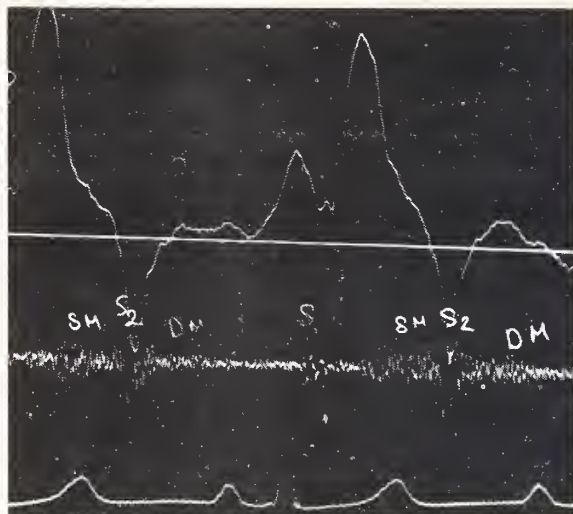
On physical examination he was a well developed, well nourished, somewhat anxious boy in no acute distress. He weighed 17 kilograms and measured 97 centimeters in height. His heart rate, respiratory rate and temperature were normal. Blood pressure was 120/55 mm Hg. The only abnormal findings were mild cyanosis and clubbing of the nail beds. His peripheral pulses were full. Precordial maximal impulse was in the 5th left intercostal space inside the mid-clavicular line. A faint parasternal heave was felt. No thrill was palpated. On auscultation the first heart sound was normal with a single and loud second heart sound. A grade 3/6 continuous murmur was best heard under left clavicle with wide radiation all over the precordium. Another grade 2/6 ejection systolic murmur was noted along the left sternal border. An ejection systolic click was audible at the upper right sternal border.

On chest X-ray the cardiothoracic ratio was 11:18 and the apex was rounded and elevated. A concavity was noted in the pulmonary artery area at the left hilum. Pulmonary vasculature was normal. A prominent ascending aorta was noted (Fig. 4).

Electrocardiogram showed mean frontal QRS axis of  $+120$  degrees with evidence of right ventricular hypertrophy. Hemoglobin and the hematocrit were 15.7 gm % and 48% respectively.



**Figure 4.** (Case 3) Postero anterior film of the chest. Note the slightly enlarged heart. Elevated and rounded apex with concavity in the left hilar area. Pulmonary vascularities are normal. The ascending aorta is prominent with left sided aortic knob.



**Figure 5.** (Case 2) Phonocardiogram shows a continuous machinery type of murmur at the pulmonary area.

## Cardiac Catheterization

Systemic arterial blood oxygen saturation measured 79.6%. The venous catheter could not be advanced into the pulmonary artery from the right ventricle but slipped into the ascending aorta through the ventricular septal defect. The right ventricular peak systolic pressure was the same as that of left ventricle. Right ventricular angiogram demonstrated the blind pouch at the site of the outflow tract. The ascending aorta with the brachiocephalic artery were opacified from the right ventricle through the ventricular septal defect. The aortogram at the beginning of the descending thoracic aorta showed the presence of a large patent ductus arteriosus opacifying the pulmonary arteries. The pulmonary artery could not be entered through the patent ductus arteriosus by the retrograde femoral arterial catheter.

## Discussion

Pulmonary atresia with VSD is commonly considered to be the most severe variant of tetralogy of Fallot. Anatomically, the pulmonic atresia and VSD are the basic elements of what is considered by many to be only a "duology," with dextroposition of the aorta and right ventricular hypertrophy occurring secondarily. Van Praagh has even proposed the concept of a "monology," consisting of an underdeveloped subpulmonary infundibulum with a parietal band of the crista supraventricularis obstructing the right ventricular outflow, while simultaneously creating the VSD by its dissociation from the normal septal band.<sup>5</sup>



## Basic Physiology

The basic physiology of pulmonary atresia with VSD consists of right to left shunt through VSD and no direct blood flow from the right ventricle into the pulmonary artery. In order to survive, the patient needs pulmonary blood flow to keep up with the oxygen demand of the body. This is accomplished by the communication between the systemic and the pulmonary arterial circulation via the patent ductus arteriosus or by bronchial collateral circulation and sometimes by anomalous vessels communicating these two circulations. The pulmonary arterial pressure is lower than that of the systemic arterial pressure. Therefore, the blood flows from the higher resistant circulation (systemic) towards the low resistance circulation (pulmonary).

The amount of left to right shunt through these communicating channels will determine the degree of systemic arterial blood saturation. If the amount of left to right shunt is large, patients would not appear cyanotic and their exercise tolerance would be good. However, this large amount of left to right shunt may increase left atrial and left ventricular volume overload. The size of VSD is always large in this combination of anomaly. Therefore, the peak systolic pressure in both the right and the left ventricles are the same.

## General Clinical Findings

The clinical picture of these patients generally includes variable cyanosis, clubbing, various levels of exercise tolerance, hypoxic spells, and a habit of squatting. Significant clinical findings include a single second heart sound, frequently an aortic click, a parasternal heave, and evidence of a large systemic and pulmonary communication, expressed clinically by a continuous murmur on auscultation of the precordium. Radiographically, there may be absent to moderate cardiac enlargement with an elevated rounded apex ("Coeur en Sabot"), a prominent ascending aorta, absence of the main pulmonary artery segment, usually diminished pulmonary vascularity and in 25%, a right-sided aortic arch. The cardiogram demonstrates right ventricular hypertrophy, right axis deviation and right atrial hypertrophy. Left ventricular hypertrophy may also be present secondary to the increased pulmonary blood flow from the shunted blood through the patent ductus arteriosus.

## The Cardiac Catheterization

At cardiac catheterization, the *sine qua non* of the syndrome is revealed as the pulmonary artery cannot be entered from the right ventricle by the venous catheter which then preferentially slips through the VSD and into the aorta. Simultaneous measurement of right and left ventricular pressures reveals them to be identical. Oxygen saturation of the systemic arterial blood is determined by the amount of pulmonary blood flow. An injection of contrast material into the right ventricle may delineate a blind pouch at the usual site of the outflow tract and as the contrast material passes through the VSD, the ascending aorta is opacified. From a surgical standpoint, an aortogram is mandatory to demonstrate the nature of the aortopulmonary communications and the size of the pulmonary arteries. The main pulmonary artery itself is often entered only with great difficulty, and various approaches have been suggested.<sup>6</sup> Again from a surgical point of view, it is important to enter the pulmonary artery in order to determine the pulmonary vascular resistance as well as angiographically demonstrating the precise size of the pulmonary arteries. However, one must also be aware of the potential danger of entering the pulmonary artery, which may result in occlusion of the patient's only source of pulmonary blood flow.

The size of the pulmonary arteries determines whether the surgery contemplated should be merely a shunt or a total correction. If before the age of one year, surgical intervention becomes necessary. The Waterstone shunt<sup>7</sup> (anastomosis of the ascending aorta to the right pulmonary artery) is the procedure of choice. After one-year of age, the Blalock-Taussig anastomosis<sup>8</sup> (subclavian to pulmonary artery) has been chosen. However, the Glenn procedure<sup>9</sup> (superior vena cava to right pulmonary artery) has the advantage of delivering one-third of the desaturated blood directly to the pulmonary artery, thus relieving the right ventricular load and increasing the oxygen saturation of the systemic arterial blood. While these shunts may be adequate for many years, with relief of hypoxic spells and improvement of exercise tolerance, most major centers advocate total correction which was an aortic hemograft in the right ventricle communicating directly with the pulmonary artery, circumventing the atretic pulmonary valve.<sup>10, 11</sup>

The importance of identifying the anatomic basis of continuous murmurs and associated lesions cannot be over-emphasized. Since total correction is available at present, a detailed hemodynamic and angiographic evaluation of all such patients is indicated.<sup>12</sup> ◀

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BROJENDRA AGARWALA, M.D., is on Assistant Professor of Pediatrics, Rush Medical School and Attending Physician in Pediatrics at Mt. Sinai Hospital where he specializes in Pediatric Cardiology. He is a Fellow of the American Academy of Pediatrics and has published several articles.



RITA AGARWALA, M.D., is a first year resident in Radiology at Mt. Sinai Hospital. She is interested in doing research work in Nuclear Medicine.



FRED H. CUCHER, M.D., is a second year resident in internal medicine at Hines Veteran's Administration Hospital. He graduated from University of Illinois at Chicago Circle with Honors and Distinction in Psychology, and then attended Chicago Medical School.

THOMAS BAFFES, M.D., is Chairman of the Department of Surgery at Mt. Sinai Hospital and an Attending Surgeon at several other hospitals. He is also a Lecturer at DePaul University School of Law. Dr. Baffes has published numerous articles and is a member of many professional organizations.



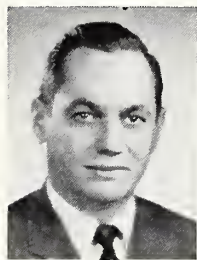
# A Case of *Hemophilus Influenzae* Meningitis With Proven Resistance to Ampicillin

HARVEY KRAVITZ, M.D., SHRINIVAS NAIDU, M.D., SUBHASH PARILEKAR, M.D. AND  
MURRAY BATT, M.D./PARK RIDGE

*There have been a number of recent reports from widely separated areas in the United States of cases of Hemophilus Influenzae type b meningitis, which have shown marked in vitro resistance to ampicillin.<sup>1-6</sup> Because of these reports the Committee on Infectious Diseases of the American Academy of Pediatrics has modified its recommendations on the treatment of H. Influenzae type b meningitis. Instead of employing ampicillin alone it now recommends that a combination of chloramphenicol and ampicillin be given in the initial treatment of suspected or documented cases of H. Influenzae type b meningitis.<sup>7</sup> It also recommends when the patho- has been identified treatment with the appropriate single antibacterial agent be used. This paper reports the first case of H. Influenzae type b meningitis with proven resistance to ampicillin in Illinois.*

## Case Report

A three-month-old white male was admitted to Lutheran General Hospital, Park Ridge, Illinois, with a history of fever, refusal to feed and irritability one day prior to admission. On examination he appeared critically ill. A dusky color and lethargy were present. No meningeal signs were noted but his anterior fontanelle was bulg-



HARVEY KRAVITZ, M.D. is a practicing pediatrician from the Department of Pediatrics, Lutheran General Hospital, Park Ridge, Illinois. He is a member of the National Accident Prevention Committee of the American Academy of Pediatrics, and a member of the Child Health Committee of the National Safety Council.

MURRAY D. BATT, M.D. is on the medical staff at Lutheran General Hospital and the attending staff at the University of Illinois Hospital. He has published several articles and is particularly interested in infectious disease.



SHRINIVAS H. NAIDU, M.D. is a clinical assistant professor of pediatrics at Abraham Lincoln School of Medicine where he is also director of the Pediatric Intensive Care Unit. He is associate director of the Pediatric Residency Program at Lutheran General Hospital.

SUBHASH G. PARALIKAR, M.D. is a pediatric resident at the University of Illinois Hospital.

ing. The rectal temperature was 103°F. (39.4 C.), the respiratory rate 70/min. and the heart rate 160/min. A grade four pan-systolic murmur was present over the left sternal border and had been noted since birth. A lumbar puncture on the day of admission revealed a turbid spinal fluid. The spinal fluid leukocyte count was 4,300/cu mm. The differential showed 80% neutrophils, 12% lymphocytes and 8% monocytes. The spinal fluid protein was 257 mg/%. The spinal fluid glucose was 13 mg/%, while the blood glucose was 89 mg/%. A Gram stain showed gram negative rods.

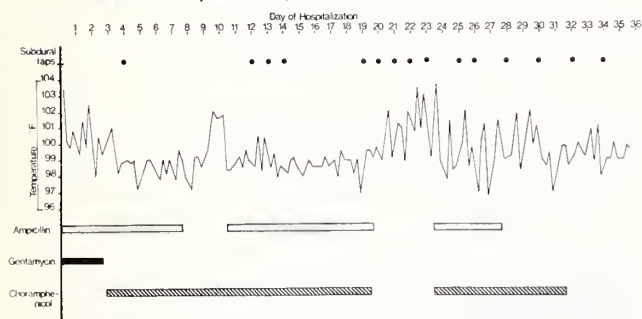
## Course of Hospitalization

The patient was started on ampicillin 300 mg/kg/daily and gentamicin 7.5 mg/kg/daily. The day after admission he had several periods of apnea and one severe generalized seizure. His pupils were dilated and his blood pressure decreased to 80/40 mm Hg. Valium and dexamethasone were given in doses sufficient to combat possible cerebral edema. Both blood and spinal fluid cultures grew *H. Influenzae*. Therefore, the gentamicin was discontinued. On the third day the spinal puncture was repeated because of continuing seizures and high fever. The spinal fluid leukocyte count was 1,119/cu mm with 95% neutrophils and 5% lymphocytes, protein was 64 mg/%. The spinal fluid glucose was 33 mg/%, while blood glucose was 119 mg/%. Gram negative bacilli were again noted in the second spinal fluids. Intravenous chloramphenicol, 100 mg/kg/day was started in combination with the am-

picillin. On the fourth day, because of continuing seizures, a subdural tap was performed obtaining 5 cc of fluid on the left side which grew gram negative rods.

The seizures subsided on the fifth hospital day and the temperature remained normal from the fifth to the ninth hospital day. Ampicillin was discontinued on the eighth hospital day. On the tenth day of hospitalization, the temperature rose to 102°F (38.8C) rectally. A repeat subdural tap revealed 15 cc of fluid on the right side and 6 cc on the left. A Gram stain and culture of the subdural fluid were negative. Intravenous ampicillin was restarted and the temperature returned to normal on the tenth hospital day and subsequently remained normal. Ampicillin and chloramphenicol were discontinued on the nineteenth hospital day, but were restarted on the twentieth hospital day because of a rise of the temperature

FIGURE 1  
Fever course and days of subdural taps and administration and cessation of antibiotics



to 102°F (38.8C). The patient became alert and active and free of seizures. Repeated blood cultures and subdural fluid cultures were negative. Ampicillin was discontinued on the twenty-fourth day and chloramphenicol stopped on the twenty-eighth day. He required repeated subdural taps before dry taps were obtained (Fig. 1). He was discharged after 36 days of hospitalization. Follow-up neurologic examinations, including hearing tests, show the infant free of neurologic sequelae.

### Discussion

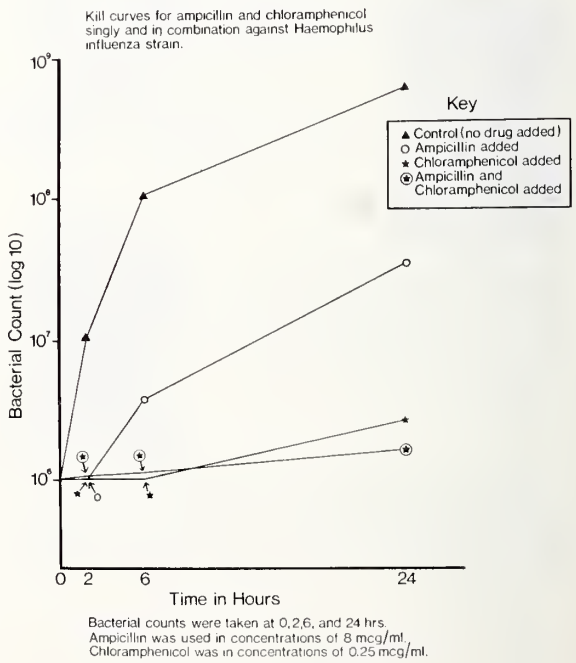
The patient was started on gentamycin and ampicillin to cover the possibility of treating *E. coli* meningitis, as well as *H. Influenzae* meningitis. Intravenous chloramphenicol was begun because of the development of severe seizures, episodes of apnea and the persistence of large numbers of leukocytes in the spinal fluid after the second lumbar puncture when the patient was on ampicillin. The excellent clinical response of the patient when both antibiotics were

being administered and the recurrence of the fever after the ampicillin was discontinued on the eighth hospital day gave rise to the possibility of a synergistic effect of ampicillin in combination with chloramphenicol.

In an effort to determine whether resistance of *H. Influenzae* to ampicillin was present and if a synergistic effect on the combination of these antibiotics had occurred, an isolate was sent to the Illinois Department of Public Health Laboratories and the Center for Disease Control (CDC) in Atlanta, Georgia for testing. Both laboratories confirmed the existence of resistant *H. Influenzae* from the isolates. The results of testing at CDC on the isolate of this patient showed that the ampicillin MIC (minimal inhibiting concentration) was 16 µg/ml and the chloramphenicol MIC was only 0.5 µg/ml, clearly indicating resistance of the isolate to ampicillin. Special testing, including checkerboard and kill curve tests using two antibiotics, indicated that the ampicillin MIC was 4 µg/ml in the presence of .25 µg/ml of chloramphenicol. But this was only one dilution under the 0.5 µg/ml which was the MIC of chloramphenicol, the most active of the two antibiotics, and cannot be considered as evidence of synergism. The results indicated test variability rather than additive effect.

Kill curves were done at CDC to test the *H. Influenzae* type b isolate with ampicillin 8 micro µg/ml, chloramphenicol at .25 µg/ml, and a com-

FIGURE 2





bination of the two antibiotics at these concentrations. The two antibiotics were added at two hours with bacterial counts at 0, 2, 6 and 24 hours. The results are summarized in Figure 2. These indicate that the control cultures increased more than  $2\frac{1}{2}$  logs, the ampicillin alone culture increased  $1\frac{1}{2}$  logs and the chloramphenicol alone, as well as the combination of chloramphenicol and ampicillin cultures, both showed no change. Had synergy been present, there would have been a large decrease in the number of viable cells with the combination of both drugs, as compared to chloramphenicol alone.

### Conclusions

It is recommended that centralized testing of isolates from cases of H. Influenzae meningitis be carried out in metropolitan areas to obtain epidemiologic information on the prevalence of resistant strains. Physicians should recognize that chloramphenicol plays a principal role in the primary treatment of meningitis in infancy and early childhood, before a pathogen has been identified, as well as in the treatment of documented cases of H. Influenzae meningitis. It is recommended that the initial therapy of documented or suspected severe infections caused by H. Influenzae type b, such as meningitis, sepsis, epiglottitis, arthritis and cellulitis include chloramphenicol as well as ampicillin or penicillin G.

Early identification of H. Influenzae meningitis can be carried out by doing counter-current immuno-electrophoresis (CCIE). Physicians in the Chicago area can get this test performed by sending a frozen specimen of spinal fluid or blood by automobile to the Municipal Contagious Disease Hospital. The test can be performed and the causative agent identified in less than 30 minutes. This test obviates the need to wait 24 to 48 hours for bacterial culture and isolation of H. Influenzae. The (CCIE) test is of great value in partially treated cases, since it is often difficult or impossible to isolate H. Influenzae with standard bacterial culture techniques. ◀

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### Viewbox

(Continued from page 492)

**DIAGNOSIS:** This is an unusual case of secondary syphilis which involves the stomach and duodenal bulb. The patient presented a diagnostic problem and all of the diagnoses listed were considered as possibilities. At this point the patient developed skin lesions which were diagnosed by the dermatologist as characteristic for secondary lues. This was confirmed by a positive VDRL and FTA-ABS. The patient was placed on large doses of penicillin and the symptoms cleared in about 10 days and a repeat gastroscopy at that time was normal. Secondary syphilis frequently involves the stomach transiently without granuloma formation. Usually it is a transient phenomena which responds rapidly to penicillin.

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# Barratry, Champerty and Maintenance

## Tools to Discourage Frivolous Malpractice Suits

BY WAYNE A. LENCZYCKI, J.D. AND THOMAS G. BAFFES, M.D., J.D./CHICAGO

*The medical profession has been searching for legal tools to resist the barrage of frivolous malpractice lawsuits brought by overreaching personal injury attorneys. Legal tools often overlooked in the fight against those attorneys who violate the rules of ethics of the legal profession are the laws of barratry, champerty and maintenance. This article will explore the growth of the law of barratry, champerty and maintenance from their origins in the common law to the development of the modern law, with emphasis on the law of Illinois.*

*The gist of the offenses of barratry, champerty and maintenance is that the offender maliciously or officiously intermeddles in a suit in which the offender has no personal interest for an unlawful or improper motive and for the purpose of stirring up strife and litigation.<sup>1</sup> Barratry, champerty and maintenance were indictable misdemeanors at common law, punishable by fine and imprisonment.<sup>2</sup>*

### Barratry

Barratry is the old common law criminal offense of frequently exciting and stirring up quarrels and suits, either at law or otherwise.<sup>3</sup> Barratry dates from a very early period in the development of the common law and it is doubtful whether legal history accurately discloses its origin.<sup>4</sup> Barratry has been described as the trafficking and merchandising in quarrels and huckstering in litigious discord.<sup>5</sup> Blackstone described those persons who indulge in barratry as "those pests of civil society that are perpetually endeavoring to disturb the repose of their neighbors and officiously interfering in other men's quarrels."<sup>6</sup> Lord Coke described one guilty of the crime of barratry as a common mover, exciter, maintainer of suits and quarrels, either in courts or elsewhere in the country.<sup>7</sup>

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WAYNE A. LENCZYCKI, J.D., is a Chicago attorney who has testified on malpractice concerns before the Illinois Insurance Commission. He is a partner in the firm of Madan and Lenczycki, Skokie.



THOMAS BAFFES, M.D., is Chairman of the Department of Surgery at Mt. Sinai Hospital and an Attending Surgeon at several other hospitals. He is also a Lecturer at DePaul University School of Law. Dr. Baffes has published numerous articles and is a member of many professional organizations.

The law of barratry sprang from the nature of feudal society in early England. Society at that time was a much less anonymous thing than it is today. A man was tried by his neighbors and they had no use for a person who stirred up disputes and hard feelings within the community. Because of this need to keep feudal society peaceful and because of a strong dislike for the disruptions of litigation, the crime of barratry came into English common law.<sup>8</sup>

### Champerty and Maintenance

The brother offenses of barratry are champerty and maintenance. Champerty is the purchase of an interest in a dispute, with the object of maintaining and taking part in the litigation.<sup>9</sup> Maintenance is aiding a party, with money or in some other way, to prosecute or defend a suit without expectation of personal profit.<sup>10</sup> The offense of champerty differs from that of maintenance in that in the offense of maintenance the person assisting the plaintiff receives no benefit as a direct result of the litigation, while in the offense of champerty he receives a part of the proceeds of the recovery.<sup>11</sup>

Champerty and maintenance were introduced by the English courts to prohibit the assignments of choses in action and the sale and transfer of land held adversely.<sup>12</sup> The history of the developmental period of the law of champerty and maintenance reveals that British lords and nobles of that period were accustomed to purchasing disputed titles, with the view that the nobles' great power would awe into submission those who were contesting the titles. The object



of the law of champerty and maintenance was to protect the rights of the weak against the powerful and wealthy nobility and to prevent the use of power to annoy and persecute the common man.<sup>13</sup> If the courts had not developed the law of champerty and maintenance, the wealthy might have oppressed the poor and robbed them of their inheritances by bringing groundless litigation against which others might be too ignorant or poor to defend themselves.<sup>14</sup>

As champerty is often practiced, a stranger to the law suit strikes a bargain with a party to the suit by which such stranger undertakes to carry on the litigation at his own cost and risk, in consideration of receiving, if successful, a part of the proceeds or subject matter to be recovered.<sup>15</sup> Maintenance would be practiced the same way, with the exception that the person committing the crime of maintenance would not receive a part of the proceeds of the suit.

### Mischief

History's view that barratry, champerty and maintenance are *malum in se* has carried over to modern times.<sup>16</sup> The modern courts have reasoned that to allow present-day attorneys to commit barratry, champerty and maintenance with impunity would lead to the same mischief that the English courts attempted to prevent the lords and nobles of feudal England from committing. They reason that it would be a strong temptation to attorneys to annoy others by the commencement of suits without just claim or right, merely to extort money from the defendant by forcing him to buy his peace.<sup>17</sup>

This appears to be, in some medical malpractice cases, the problem facing the medical profession today. Some attorneys have filed lawsuits against physicians on very questionable grounds. They have obtained settlements from the physicians' malpractice insurance carriers because the insurance companies feared the high cost of defending such lawsuits and the possibility of high jury awards. Many of these settlements have been accomplished by applying pressure on insurance companies. It would appear that the initiation of groundless suits could be discouraged by the use of the laws of barratry, champerty and maintenance.

### Modern Common Law

The modern common law against barratry lends itself to the discouragement of specious litigation. Barratry, under the modern common law may be found to have been committed

whether the suits excited or stirred up are just or unjust well- or ill-founded.<sup>18</sup> In order to prove barratry, one must prove an intention or malicious design to oppress and harass another.<sup>19</sup> In addition, one must prove a pattern of continuously stirring up litigation, for barratry does not consist of a single act, but of several acts. The courts have held that at least three acts of a barratrous nature were necessary to constitute the offense.<sup>20</sup>

The modern common law courts have generally held that to bring a charge of barratry against an individual, the indictment must state from whom the accused sought to obtain employment.<sup>21</sup> In order for the common law indictment to be sufficient at law, it was essential that the defendant be charged with being a "common barrator," which is a term of art appropriated by the law to this crime. An indictment, without the word "barrator" is insufficient.<sup>22</sup> An additional requirement of the common law indictment was that it must charge that the offense was against the peace.<sup>23</sup> The common law further required that the prosecutor give the defendant notice, in the form of a bill of particulars, of the acts charged.<sup>24</sup> If a person were found guilty of the common law offense of barratry he would be guilty of a misdemeanor and could be punished by fine and imprisonment in the discretion of the court. If the defendant were an attorney, he could be disbarred.<sup>25</sup>

To plead champerty or maintenance effectively at common law, one must show the pendency of a suit and specify the court in which such suit is pending, as well as the time, place, and circumstances of the suit so as to show the maintenance or champerty.<sup>26</sup>

One convicted of champerty and/or maintenance is subject to the same penalties as if convicted of barratry under the criminal common law. An additional civil penalty may however, be imposed against one that has committed champerty or maintenance: in civil suits a defense of champerty or maintenance may be raised to prevent an attorney from recovering his contingent fee. The contingent fee can be denied on the theory that, regardless of its form, an agreement which is champertous in fact is void and may be rescinded as between parties. The courts will not aid either party to a champertous contract by enforcing or canceling the contract or by compelling a restoration of property parted with or money paid out under the agreement. Reasonable compensation for services rendered may be recovered on a theory of *quantum meruit* though, in the same manner as

if the champertous agreement had never existed. At common law maintenance may be redressed by an action for damages.<sup>27</sup>

### Illinois Law

In an attempt to enforce the public policy of Illinois against fomenting and maintaining litigation, the decisions of the courts of Illinois and the statutes of Illinois intended to prevent multitudinous, useless, and speculative lawsuits.<sup>28</sup>

Illinois has codified the laws of barratry and maintenance as follows:

#### *"Barratry-Penalty*

If any person shall wickedly and willfully excite and stir up any suits or quarrels between the people of this state, either at law or otherwise, with a view to promote strife and contention, he shall be deemed guilty of the petty offense of common barratry; and if he be an attorney or counselor at law, he shall be suspended from the practice of his profession, for any time not exceeding six months."<sup>29</sup>

#### *"Maintenance-Penalty-Exceptions*

If any person should officiously intermeddle in any suit that in no way belongs to or concerns such person, by maintaining or assisting either party with money or otherwise to prosecute or defend such suit with a view to promote litigation, he shall be deemed guilty of maintenance, and upon conviction thereof, shall be fined and punished as in cases of common barratry; provided, that it shall not be considered maintenance for a man to maintain the suit of his kinsman or servant, or any poor person out of charity."<sup>30</sup>

These statutes have abolished the common law offenses of barratry and maintenance in Illinois by creating statutory substitute offenses.<sup>31</sup> The common law crime of champerty has not been abolished in Illinois, but the tendency is to depart from the severity of the old law.<sup>32</sup>

Although the constitutionality of the Illinois barratry statute has not been ruled upon, such a barratry statute has been declared to be constitutional in Texas.<sup>33</sup> The court held in *McCloskey v. Tobin* that a statute defining the offense of barratry and providing for the punishment of any persons who ". . . shall seek to obtain employment in any claims, to prosecute, defend, present or collect the same by means of personal solicitation of such employment . . ." did not violate the 14th Amendment of the Federal Constitution as a prohibition of the right to do business.<sup>34</sup>

Several maintenance statutes have been held unconstitutional in recent years but they have all been in Southern states that have amended their barratry, champerty and maintenance statutes to deviate substantially from the common law. The statutes held unconstitutional were statutes designed to impede civil rights organiza-

tions, such as the N.A.A.C.P. and C.O.R.E., from bringing suit to enforce individuals' constitutional rights.<sup>35</sup> The Illinois maintenance statute apparently has been thought to be adequate by the Illinois courts and legislature since the present criminal statute, except for minor changes in the penalty, is almost identical to the first Illinois maintenance statute enacted in 1827.<sup>36</sup>

The Illinois law against champerty also must be regarded as adequate since it was adopted by incorporating the relevant substantive provisions of the common law of England, with few exceptions, in 1874.<sup>37</sup> No effort was made to exclude the common law offense of champerty or to draft a new form for the statutory offense at that time.

### Application

Now that we have discussed the origins of the law of barratry, champerty and maintenance, both at common law and by statute in Illinois, we turn to the use of these laws in medical malpractice suits in Illinois. It would appear that there is here a potential for defense of some malpractice suits.

An organization of interested individuals, possibly might consider bringing suit to enforce existing barratry, champerty, and maintenance laws against unethical attorneys. It is clear that persons taking a public-spirited interest in public prosecution will be protected from a change of barratry or maintenance by the motive prompting them to interfere.<sup>38</sup> Barratry does not consist of promoting public prosecutions or private suits when the sole object is the attainment of public justice or private rights, but solely of the use of these remedies for mean and selfish ends.<sup>39</sup> In addition, the interest of a state in restricting and regulating the practice of barratry might not permit the state to curtail the activities of a membership organization so as to prevent it from furnishing counsel to its members and others. Such an organization could possibly assist its members in litigation to secure judicial determination and enforcement of the rights of its individual members as guaranteed by the Federal Constitution.<sup>40</sup> Of course an opposite conclusion can be reached, if the design of bringing suit is not to recover in one's own right, but to ruin and oppress one's neighbor. In that case the action would be barratry.<sup>41</sup>

If an organization decides to bring charges of barratry, champerty, or maintenance, it should first look to the circumstances of the case to determine if there appears to be a pattern or history of bringing groundless suits on the part of an attorney involved. Has the attorney soli-



cited a *large number* of claims of the same nature and charged a fee for his services in connection with the claims, contingent on the amount recovered?<sup>42</sup> Although the common law required that three acts were necessary to constitute barratry, there have been no court rulings in Illinois on this point.<sup>43</sup> Even if it appears that Illinois may in the future hold that three acts of barratry are required for conviction, a person may be properly tried and convicted of the offense of an "attempt" to commit barratry upon an indictment charging the common law offense of barratry.<sup>44</sup>

### Evidence for Champerty

If, after investigation, it is found that there has been an agreement to conduct litigation, or to pay costs and expenses of suit, or to advance money therefor, all in consideration for a portion of the recovery, that is champerty.<sup>45</sup> To prove a case of champerty, it is not sufficient to show that a part of the thing recovered was paid or agreed to be paid as an attorney's fee, but it must be shown that the costs and expenses of the suit, or some part of them, were paid or agreed to be paid by the champertee.<sup>46</sup>

The law will not allow a person to advance for another the costs and expenses of litigation in consideration of deriving some benefit from the outcome thereof.<sup>47</sup> One must remember, however, that a contract for a contingent fee is not champertous in Illinois.<sup>48</sup> Nor is a contract to pay an attorney a contingent fee champertous.<sup>49</sup> To establish champerty, it must be shown that the attorney entered into an agreement with the client to represent the client in certain litigation and agreed to pay costs and expenses of litigation himself. It is not relevant to the action that the attorney made advancements for the client's use.<sup>50</sup> Any contract whereby a client is prevented from settling or discontinuing his suit is void, since such agreement would foster and encourage litigation.<sup>51</sup>

Other evidence of champerty includes the soliciting of legal business, furnishing attorneys, and the division of fees.<sup>52</sup> The soliciting of legal business by attorneys is barred by Canon 28 of the Canons of Ethics of the Illinois State Bar Association and Chicago Bar Association, which provides as follows:

"It is disreputable . . . to breed litigation by seeking out those with claims for personal injuries . . . in order to secure them as clients, or to employ agents or runners for the purposes, or to pay or reward, directly or indirectly, those who bring or influence the bringing of such cases to his office or to remunerate policemen, court or prison officials, physicians, hospital attaches or others who may succeed, under the guise of giving disinterested friendly ad-

vice, in influencing the criminal, the sick and the injured, the ignorant or others, to seek his professional services.<sup>53</sup>

In addition, the Illinois Code of Professional Responsibility provides that attorneys shall avoid the acquisition of an interest in litigation. DR 5-103 provides:

(A) A lawyer shall not acquire a proprietary interest in the cause of action or subject matter of litigation he is conducting for a client, except that he may:

- (1) Acquire a lien granted by law to secure his fee or expenses.

- (2) Contact with a client for a reasonable contingent fee in a civil case.

(B) While representing a client in connection with contemplated or pending litigation, a lawyer shall not advance or guarantee financial assistance to his client, except that a lawyer may advance or guarantee the expenses of litigation, including court costs, expenses of investigation, expenses of medical examination, and costs of obtaining and presenting evidence, provided the client remains ultimately liable for such expenses.<sup>54</sup>

While there have been relatively few reported cases in Illinois dealing with the Illinois barratry and maintenance statutes, there have been many attorneys disciplined for solicitation. Mr. John F. McBride, Executive Director of the Chicago Bar Association and Mr. John M. Oswald, Assistant Administrator and Chief Investigator of the Illinois Supreme Court Attorney Registration and Disciplinary System, both commented to the writer that, although they knew of no recent cases dealing with the barratry and maintenance statutes, they agreed that the majority of cases of this nature were brought under a charge of solicitation.<sup>55</sup>

### Inhibiting Penalties

The penalty that may be imposed, under the Illinois barratry and maintenance statutes, upon a person convicted, is that he shall be guilty of a petty offense and, if he is an attorney, he will be suspended from the practice of law for a time not exceeding six months.<sup>56</sup> The term "petty offense," as defined by the statute, means any offense for which a sentence of a fine of up to \$500 but not incarceration may be imposed as a sentence.<sup>57</sup>

In view of the severity of the suspension provisions, it is possible that the existing prohibitions against barratry, champerty and maintenance, as enforced against those participating in the unethical filing of bad faith lawsuits might produce a means of defending or reducing the groundless suits which are filed. ◀

### References

A list of references for "Barratry, Champerty and Maintenance" is available to ISMS members and may be obtained by writing *IMJ*, 55 E. Monroe, Suite 3510, Chicago 60603.

# Transport of High Risk Neonates

## Part I: Clinical and Metabolic Observations

BY RAJAM S. RAMAMURTHY, M.D., MRIDULA REVERI, M.D., SUMA P. PYATI, M.D.  
AND MARIO REALE, M.D./CHICAGO

Division of Neonatology, Cook County Hospital,  
Hektoen Institute for Medical Research, University of Health Sciences/The Chicago Medical School.

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*This is the first of two articles dealing with transportation of the high risk newborn.*

Recent advances in Perinatal and Neonatal Medicine have largely contributed to the decline in neonatal morbidity and mortality.<sup>1-3</sup> Highly specialized perinatal intensive care units with round the clock availability of multiple subspecialty services necessitates centralization of such facilities. Optimally, high risk mothers should be delivered at such centers. However, because of limits on resources, patient and physician preferences and the novelty of the approach, it will be some time before the practice becomes routine. Until such time, sick neonates will continue to be transported from peripheral hospitals to perinatal centers. The benefits of transfer must outweigh the potential risks and inconveniences

of the procedure.

In this report, we review our two year experience with the high risk infant transport program implemented at Cook County Hospital in January, 1974, a year prior to the regionalization of perinatal care in the state of Illinois. In January, 1975, Cook County Hospital was designated as one of the six regional perinatal centers in the Chicago metropolitan area. The efficacy of the transport program as measured by mortality, clinical course and metabolic observations on the neonates transferred to the unit is presented. In a subsequent issue, an outline for initiating short term intensive care for the high risk infant will appear. It is hoped that this would serve to guide the physician at the peripheral hospital to initiate intensive care so as to maximize an infant's chance for normal survival.

Between January 1, 1974 and December 31, 1975, 352 infants were transported for the following reasons: respiratory distress (159), low birth weight, <1500 gm (67), suspected sepsis (22), congenital anomalies (19), aspiration (20), jaundice (14), seizures (9), congenital heart disease (14), drug withdrawal syndrome (6), infants of diabetic mothers (5), repeated apneic episodes (2) and others (15).

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Dr. Rajam S. Ramamurthy is Assistant Director at the Division of Neonatology at Cook County Hospital, as well as Assistant Professor of Pediatrics at the University of Health Sciences/Chicago Medical School.

Mridula Reveri, M.D., Suma P. Pyati, M.D., and Maria Reale, M.D., are Fellows, Division of Neonatology, Cook County Hospital.



Referrals were made from the community hospital by the pediatrician in 75% of the cases and by a nurse with the knowledge of the attending pediatrician in 25%. All calls were made directly to the Neonatal Intensive Care Unit (NICU) via a hot line number. Direct consultation with the neonatology staff provided the opportunity to judge the urgency of the call and for treatment suggestions in the interim period.

The transport team consisted of a neonatology fellow and nurse from the special care nursery at Cook County Hospital. Other pediatric house staff or medical students accompanied the team as a learning experience.

At the program's inception, an ambulance from the Chicago Board of Health (CBOH) was employed, but it became apparent that the CBOH would not be able to provide the number of transports undertaken by the six centers in the city. Therefore, the hospital contracted with a commercial ambulance company. A mobile transport incubator provided by the NICU was used for all transports. Accompanying the team was equipment for cardiac and pulmonary resuscitation, thoracentesis, umbilical vessel catheterization and continuous positive airway pressure (CPAP). Monitors for heart rate, temperature, oxygen concentration and emergency medications were also carried by the team.

The procedures performed by the team before transporting the infant were: establishment of peripheral intravenous line in 78, umbilical arterial or venous catheterization in 9 and chest

tube insertion in 2 infants. Endotracheal intubation was done in 71 infants, 16 of whom required CPAP and the rest bagging with 100% oxygen during transit. Sodium bicarbonate was given to 19, blood transfusion to 2 and albumin to 5 infants.

## Evaluation of Transport Procedure

### *Transit Time*

The commercial ambulance arrived at the center to pick up the transport team in a significantly ( $p < .01$ ) shorter period of time in infants who subsequently died than in those who lived (Table 1). Thus, the urgency of the call was accurately transmitted to the ambulance company. In 1975, the total transport time was significantly greater in infants who died,  $101.8 \pm 35.5$  minutes (mean  $\pm$  S.D.) than in those who lived,  $82.7 \pm 32.3$  minutes. This was not seen in 1974 and perhaps reflects the current emphasis placed on stabilizing the infants' condition prior to transport. Most of the referring hospitals were fifteen minutes to an hour away from the center in non-rush hour periods.

### *Birth Weight and Gestational Age*

The mean  $\pm$  S.D. gestational age of infants who lived,  $2223 \pm 874$  grams (1974) and  $2215 \pm 920$  grams (1975) is significantly higher than those who died,  $1521 \pm 896$  grams (1974) and  $1508 \pm 904$  grams (1975).

There were 15 babies in 1974 and 23 in 1975 who weighed less than 1000 grams. The overall

**Table 1**

	1974		1975	
	Lived	Died	Lived	Died
Ambulance Arrival Time (minutes)	$40.3 \pm 19.3^{**}$	$31 \pm 10.3$	$37.6 \pm 25.6^{**}$	$29.8 \pm 10.5$
Total Transport Time (minutes)	$72.6 \pm 10.3$	$75 \pm 31.4$	$82.7 \pm 32.3^{**}$	$101.8 \pm 35.5$
Birth Weight (grams)	$2223 \pm 874^{***}$	$1521 \pm 896$	$2215 \pm 920^{***}$	$1508 \pm 904$
Overall Mortality %	20		21.3	
Mortality in Infants Weighing < 1000 gm %	60		65.2	
Temperature °F	$97.5 \pm 1.5^{***}$	$96.2 \pm 1.7$	$97.5 \pm 1.4^{***}$	$95.9 \pm 1.4$
pH	$7.26 \pm 1.0^{**}$	$7.17 \pm .13$	$7.32 \pm .11^{***}$	$7.23 \pm .15$
Blood Glucose (mg%)	$99.5 \pm 87^*$	$202.6 \pm 143.6$	$85.8 \pm 52.7^*$	$174.9 \pm 209.7$

Values indicate Mean  $\pm$  S.D.

\*P < 0.05

\*\*P < 0.01

\*\*\*P < 0.001

mortality of 63% in these infants is less than that seen for inborn babies at the center.

The mortality with respect to gestation shows the expected high rate with lower gestations and a rise beyond 41 weeks due to the complications of postmaturity (28 wk. 53%, 29-32 wk. 22%, 33-41 wk. 8.9%, > 41 wk. 33%).

#### *Temperature, Acid-base Status and Plasma Glucose (Table 1)*

Rectal temperatures were recorded by transport team on arrival at the referring hospital and again upon arrival at our NICU. Infants who died had significantly lower body temperature prior to transfer and the temperature remained lower on arrival at the NICU ( $p < .001$ ). Many of the sick infants were rushed immediately into the unit and therapy started before temperatures were taken.

Infants who died had a significantly greater degree of metabolic acidosis on the first blood gas determination upon arrival in the NICU. This was reflected by lower pH and greater base deficit in infants who died than in those who lived ( $p < .01$ ). Some of these infants had been given sodium bicarbonate by the transport NICU physician on clinical grounds.

Plasma glucose values were higher ( $p < .01$ ) in infants who died. Hyperglycemia ( $> 125\text{mg}\%$ ) was seen in 7 of the 14 infants who died as compared to 10 of the 50 who lived. This difference was statistically significant ( $p < .05$ ).

#### *Autopsy Findings*

Intracranial hemorrhage and pulmonary hemorrhage were the most commonly observed findings. Severe bilateral atelectasis, meconium aspiration syndrome and congenital heart disease were the other causes of death.

### **Discussion**

Prior to regionalization of perinatal care in the state of Illinois in January, 1975, units such as ours interested in providing care for sick neonates had to develop an independent transport program. In our situation, since the transport costs were charged to the operating expenses of the unit, a simple inexpensive transport system was required. Fully equipped and luxurious vehicles could not be employed. A single ambulance company under contract to and paid by the hospital provided adequate service. The key to safe transport is competent professionals and adequate portable equipment.

The overall mortality of infants who were transported was 20.5%. This is similar to 22.6% reported by Cunningham et al,<sup>4</sup> and lower than 25% reported by Chance et al.<sup>5</sup> Comparison between transport systems is not always possible because of dissimilarities in population, geography, primary diagnosis and initial care given to the infant at the peripheral hospitals. The high mortality encountered in infants of lower birth weight and gestational age was not unexpected.<sup>6</sup> This emphasizes the need to put forth effort to reduce the incidence of low birth weight if a significant decrease in overall mortality is to be achieved.

The lower mortality among transported infants who weighed  $< 1000$  grams compared to inborn babies at Cook County Hospital may reflect that many small prematures die before transfer and only those who are not terminal in the first 1-2 hours after birth get transported. This has to be verified by comparing the overall mortality statistics of the referring hospitals.

The clinical and metabolic observations bring out several important points. Efforts to increase the body temperature during transit in infants who start with lower temperatures is not always successful. This is particularly true when the incubator is opened in order to perform procedures in very sick infants. Metabolic acidosis was common and persistent in sick infants even though bicarbonate had been administered prior to the move. Since blood gases were not frequently available in referring hospitals, it is apparent that acidosis, although predicted, is frequently underestimated. However, there is a significant improvement in the initial pH in 1975. This perhaps indicates that the need for acid base correction and adequate oxygenation is better understood by community hospitals and the transport team.

Hyperglycemia was more common in infants who died than in those who lived. This finding previously observed by us<sup>7</sup> occurs even when  $4.2\text{ mg/kg/min}$  of glucose in water is infused. Dextrox or blood sugar determination prior to transfer may be helpful in deciding the actual needs of the infant.

The impact of a transport program on neonatal mortality can only be made from evaluating the mortality statistics of referring hospitals. Preliminary data from hospitals related to our program indicates a fall in neonatal mortality especially when early referrals are made. In connection with the implementation of the regional



perinatal program, a mechanism is being evolved for critical evaluation of these statistics. In the meantime, early transport of high risk neonates appears to be a safe and important aspect of neonatal intensive care. ◀

*The December IMJ will carry part two of this series, which extends consideration to stabilization of the neonatal environment during transportation and anticipation of pre-delivery complications.*

#### Acknowledgement

The authors wish to thank the Neonatology Fellows and NICU Nurses who transported the infants and maintained records.

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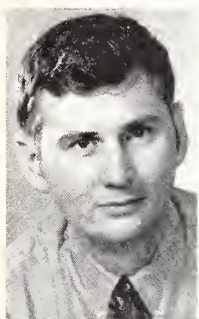
Richard A. Ott, Managing Editor

# Development and Implementation of a Plan for Perinatal Health in Illinois

BY GERALD F. STAUB, M.D./ROCKFORD AND JAMES P. PAULISSEN, M.D./WHEATON

*The implementation of the Illinois Perinatal Plan<sup>1</sup> was begun January 1, 1975, and is characterized by the multifaceted Perinatal Program (See Fig. 1) a portion of which the Illinois Department of Public Health (IDPH) administers. The basic funding of patient care costs and transportation for high risk mothers and newborns in ten regional perinatal intensive care centers (See Fig. 2) is provided by the Illinois Legislature. Each Center has the responsibility of providing services for the patients and hospitals which it serves. There is a high level of sophistication and quality in care, encompassing consultation in medicine, nursing 24 hours a day, and transportation coordinated with the Division of Emergency Medical Services. Other services provided by the centers include a collecting and reporting system, communication with the referring physician and local health department to allow for proper follow-up and nursing care, and a variety of educational and outreach activities designed to assist the community hospital in achieving optimum care. Furthermore, IDPH strongly encourages county and local health departments to provide preventive perinatal health services and supports the development of health departments in 69 Illinois counties without basic health services.*

As the Perinatal Program in Illinois is composed of many active elements, the identification of these elements and their respective roles is most helpful in elucidating the philosophy of the Program. The primary health care system and the community hospital are the key elements in terms of numbers of patients, providers and resources. For this reason, the other elements of the Program must be organized and coordinated to support these key elements.



GERALD F. STAUB, M.D., is Chief of the Section of Neonatology at Rockford Newborn Center, Assistant Professor of Pediatrics at the University of Illinois, Rockford School of Medicine, and Director of the High Risk Newborn Center at Rockford Memorial Hospital. Dr. Staub is also involved in the development of a High Risk Perinatal Referral Center for Northern Illinois and is a member of the Illinois Committee for Perinatal Health.

JAMES P. PAULISSEN, M.D., M.P.H., is Executive Director of the DuPage County Health Department. He was formerly Chief of the Division of Family Health of the Illinois Department of Public Health and a Clinical Associate in Pediatrics at Southern Illinois University. Dr. Paulissen has been involved with maternal and child health in Illinois for the past ten years.



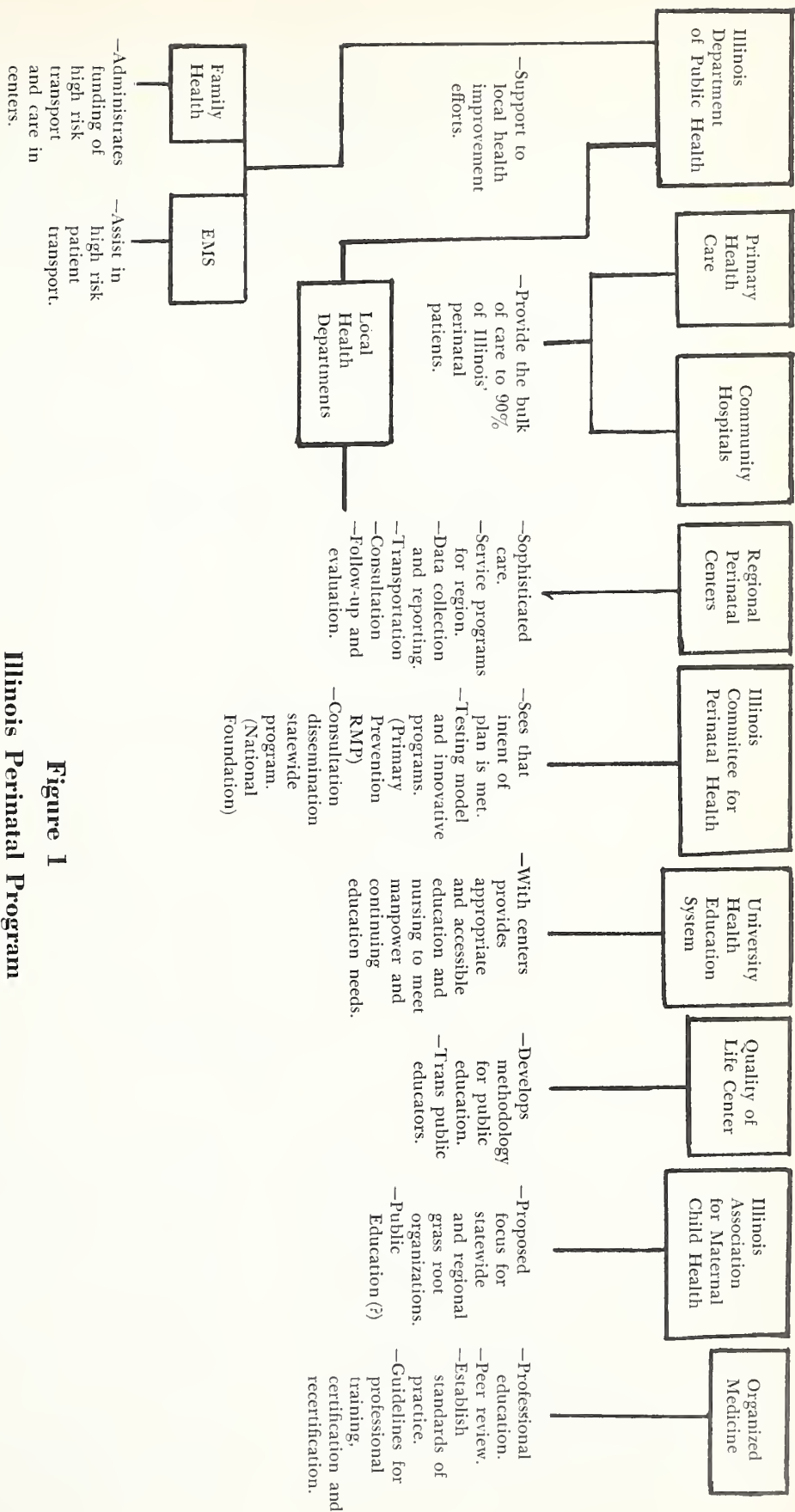
The orientation of the Perinatal Center, the University based health education system and educational groups, such as the Illinois Association for Maternal and Child Health (IAMCH), is toward a pattern of two directional flow with the community, its hospital(s) and providers, so that service and educational activities are taken to the people who need them and are tailored to community needs (See Fig. 3).

From the community, there is return flow in the form of patient referral, feedback of ideas, joint planning for the best use of community and regional resources, and meaningful evaluation of Center programs and services. Local monies make possible support for local perinatal health programs and education of professionals through purchasing the time of Center staff in consultant, teaching and hospital visitation activities. These monies also support other activities which benefit the region as a whole, such as an evaluation service for high risk newborns, a regional advisory council of providers and consumers and home nursing services to counties without health departments.

## Role of the Illinois Committee for Perinatal Health

The Illinois Committee for Perinatal Health is concerned that the input of the Perinatal Plan is met as intended, as well as aiding in





**Figure 1**  
**Illinois Perinatal Program**

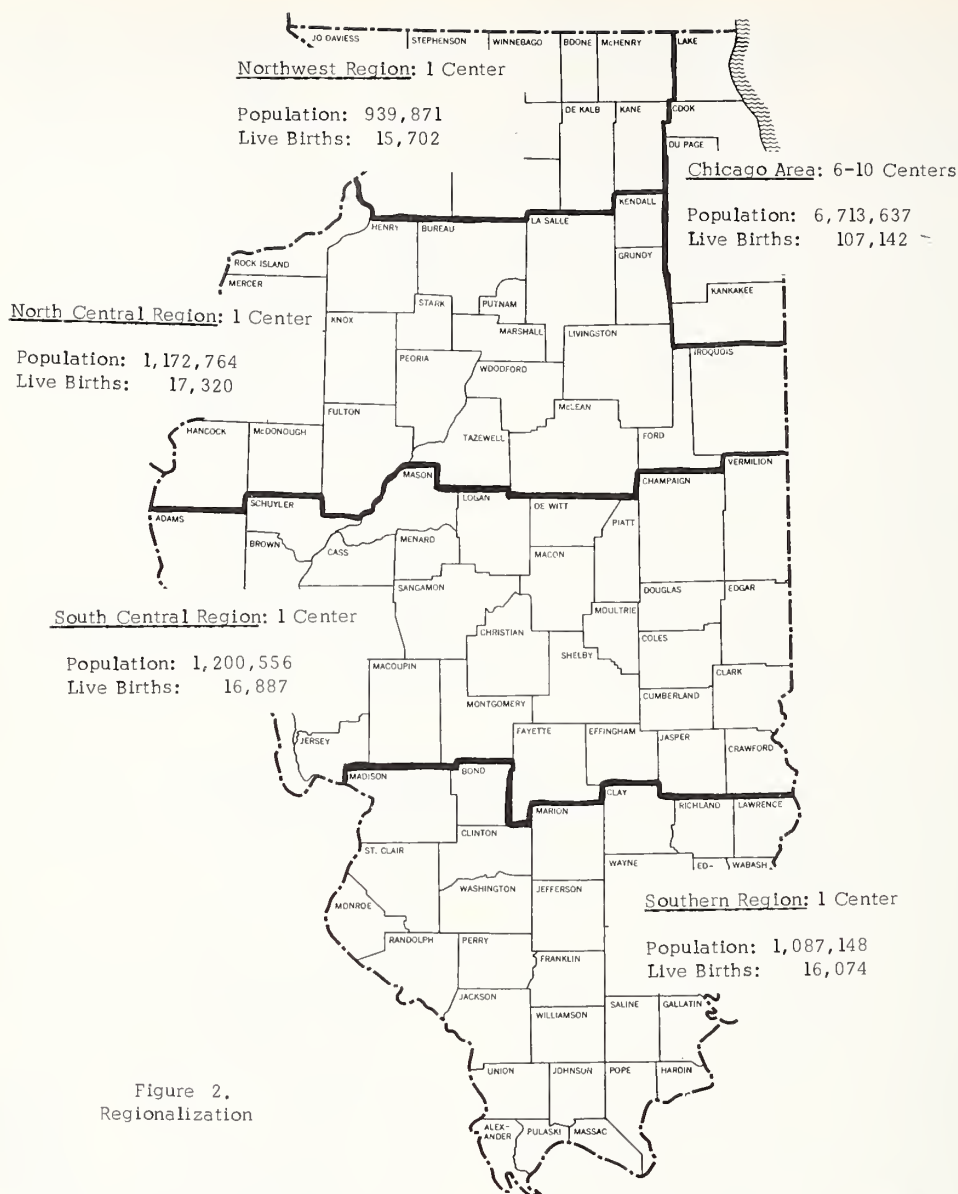


Figure 2.  
Regionalization

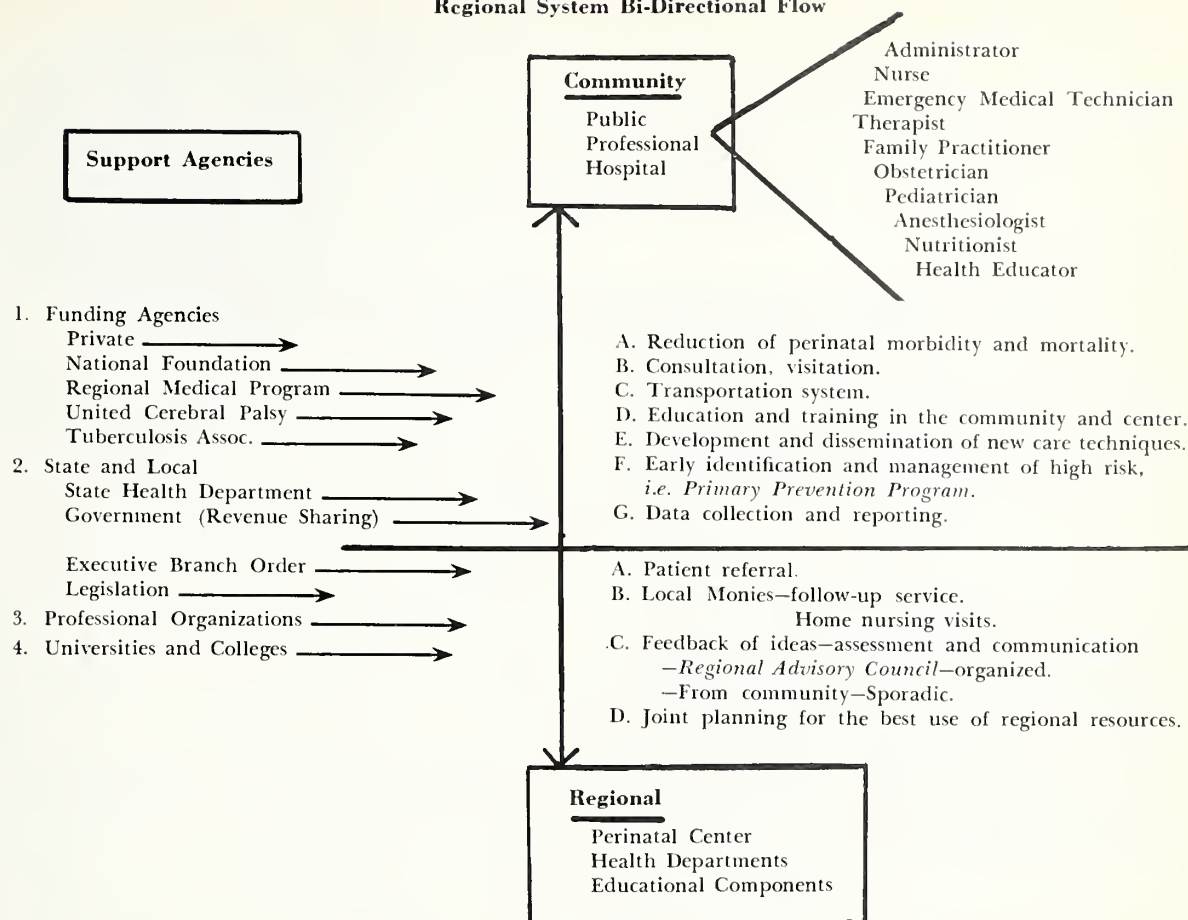
accomplishing some of the major recommendations<sup>2</sup> of the Plan through innovation. The principal program, funded by the National Foundation—March of Dimes, is implemented by the Illinois Committee for Perinatal Health, which assists the Perinatal Centers in expediting their consultation, education and outreach activities to professionals and hospitals through nursing consultants, planning and coordinating expertise, supplemental funds and evaluation support not otherwise available. A statewide coordinator plays a vital part in this program by organizing perinatal education and training among the Centers and the University education system in order

to readily reach all providers with what they need to give, *more* quality care, and to avoid costly duplication. The coordinator's organization and coordination activities include the identification of needs, educational opportunities and special skills available, the development of a plan of objectives based on the orientation of each Center and University sponsored educational activity to their special skill areas and financial and logistical support for carrying out these activities. In this way the activity can be easily repeated anywhere in the state and yet is unique in that it tends not to duplicate what other Centers or education systems are doing.



Figure 3

Regional System Bi-Directional Flow



Another Major Program

Another major development of the Illinois Perinatal Plan is a model primary prevention program, funded by Illinois Regional Medical Program and implemented by the Illinois Committee for Perinatal Health. The purpose of this primary prevention program is the early identification, continuing management and follow-up of those high risk adolescents, pregnant women and their offsprings without primary physicians. This program is being tested before recommending that IDPH fund similar programs in areas of need throughout Illinois. The Committee is also testing the regional advisory council concept as a means of providing continuing assessment and feedback of ideas to perinatal centers as well as to identify problems and assist in mobilizing regional or local resources for solving problems in perinatal health within the region.

The IAMCH, because of its excellent cross-sectional consumer and professional membership, is the logical proposed focus for statewide and regional grass root organizations for those

interested in improving perinatal health. Finally, because consumer education must be concomitant with professional education, elements within the Perinatal Program are turning their attention to proposal of a program for consumer education. This commitment would be a major effort to reorder public policy so as to establish the reproductive years of life as being number one in priority for availability and utilization of health legislation, funds, manpower and other resources. Reordering public policy through education is the most important facet of the Program. Without public recognition and demand for action, we will pass our 200th year and subsequent years without the necessary attitudes, manpower, resources and application of technology that could enable us to reduce perinatal mortality by 50%<sup>3</sup> in the next five years.

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## EKG

(Continued from page 499)

**Answers: 1. A,B,D 2. E**

The ECG shows significant Q waves in leads II, III, avF, and V<sub>6</sub> associated with T wave inversions. This is an inferior and lateral myocardial infarction. There is almost no ST segment elevation seen to confirm the impression of recent myocardial injury. However, the clinical impression of acute myocardial infarction must be followed. The broad R wave in lead V<sub>1</sub> and the tall R wave in lead V<sub>2</sub> are strongly suggestive of a true posterior or dorsal wall myocardial infarction. The ECG would suggest, that a large dominant right coronary artery with branches to the posterior and lateral left ventricular wall, has been proximally occluded. Standard coronary care unit procedures were followed. Serial serum enzymes and ECGs confirmed the acute myocardial infarction. The patient had no further chest discomfort and overall made an uncomplicated recovery.

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SPECIALTY REVIEW THORACIC SURGERY, February 21  
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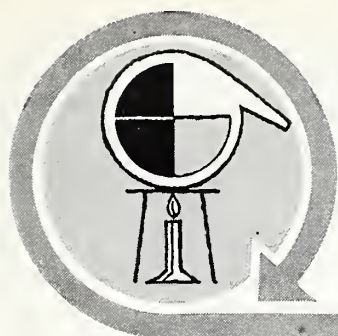
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# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

The following new drugs have been marketed:

## NEW SINGLE DRUGS

**LOXITANE C** Ataraxic Rx  
 Manufacturer: Lederle Laboratories  
 Nonproprietary Name: Loxapine HCl  
 Indications: Manifestations of schizophrenia  
 Contraindications: Comatose or severe drug-induced depressed states  
 Dosage: Initial 10 mg twice daily, maintenance range 60 to 100 mg daily  
 Supplied: Solution in 4 oz bottles, ml/25 mg

## DUPLICATE SINGLE DRUGS

**HYPROVAL** Progesterone Rx  
 Manufacturer: S. J. Tutag & Co.  
 Nonproprietary Name: Hydroxyprogesterone Caproate  
 Indications: Amenorrhea and related conditions  
 Contraindications: Those usual for progesterone  
 Dosage: 375 mg, i.m.  
 Supplied: Castor oil solution, ml/250 mg

**NOVAFED A** Nasal Decongestant Rx  
 Manufacturer: Dow Pharmaceuticals  
 Composition: Pseudoephedrine HCl 120 mg  
 Chlorpheniramine maleate 8 mg  
 Indications: Relief of nasal congestion in upper respiratory infections  
 Dosage: One capsule every 12 hours  
 Supplied: Capsules

**PYRACORT-D** Nasal Decongestant Rx  
 Manufacturer: Lemmon Pharmacal Company  
 Nonproprietary Name: Phenylephrine HCl  
 Indications: Temporary relief of nasal congestion  
 Administration: Two or three sprays in each nostril 3 to 4 times daily  
 Supplied: Spray bottle, 22.5 ml; 0.5%

## SK-LYGEN

Manufacturer: Smith Kline & French Laboratories  
 Nonproprietary Name: Chlordiazepoxide HCl  
 Indications: Relief of anxiety and tension  
 Warnings: Avoid combined effect of alcohol and CNS depressants  
 Dosage: 5 to 10 mg three to four times daily, adjust to patient's response.  
 Supplied: Capsules, 5, 10 and 25 mg

## X-OTAG Inj

Manufacturer: Muscle Relaxant Rx  
 Nonproprietary Name: S. J. Tutag & Co.  
 Indications: Orphenadrine Citrate  
 Painful musculo-skeletal conditions  
 Contraindications: See package insert  
 Dosage: 2 ml; i.m. or i.v. every 12 hours  
 Supplied: Vials, 10 ml, ml/30 mg

## COMBINATION PRODUCTS

**ASBRON G** Bronchial Dilator Rx  
 Manufacturer: Dorsey Laboratories  
 Composition: Tablets Elixir  
 Theophylline Sod. Glycinate  
 300 mg 5 ml/300 mg  
 Guaifenesin  
 100 mg 5 ml/100 mg  
 Indications: Acute bronchial asthma and reversible bronchospasm  
 Contraindications: Peptic ulcer  
 Dosage: Adults—1 or 2 tablets or teaspoon elixir t.i.d. or q.i.d.  
 Supplied: Tablets and Elixir

## NATACORT

Manufacturer: Prenatal Vitamins Rx  
 Composition: Parke-Davis  
 9 Vitamins  
 Folic Acid, Calcium, Magnesium, Iodine and Iron  
 Indications: Nutritional support in pregnancy  
 Dosage: One tablet daily  
 Supplied: Coated tablets

## PROMEX

Manufacturer: Cough Preparation Rx  
 Composition: Lemmon Pharmacal Company  
 Promethazine HCl 5 mg  
 Ipecac fl. extract 0.011 ml  
 Potassium  
 guaiacolsulfonate 44 mg  
 Chloroform, Citrates

Indications: Relief of coughs due to colds  
 Dosage: One or two teaspoonfuls every four to six hours  
 Supplied: Syrup, bottles 4 fl oz and pints

**TRIPHED** Nasal Decongestant Rx  
 Manufacturer: Lemmon Pharmacal Company  
 Composition: Triprolidine HCl 2.5 mg  
 Pseudoephedrine HCl 60 mg  
 Indications: Allergic and vasomotor rhinitis  
 Dosage: Adults and children over 6 years of age—I tablet two or three times daily  
 Supplied: Tablets

**WYCILLIN Inj & PROBENECID** Antigonorrheal Rx  
 Manufacturer: Wyeth Laboratories  
 Composition: Disposable syringe, Penicillin G, Procaine, 2,400,000/4 ml  
 Tablets, Probenecid 500 mg  
 Indications: Single dose treatment of gonorrhea  
 Contraindications: Blood dyscrasias and uric acid kidney stone  
 Dosage: One injection of 2,400,000 each injected at two different sites. Two tablets probenecid.  
 Supplied: Package; 2 syringes and 2 tablets

**X-OTAG Plus Tablets** Muscle Relaxant Rx  
 Manufacturer: S. J. Tutag & Co.  
 Composition: Orphenadrine Citrate 50 mg  
 Acetaminophen 325 mg  
 Indications: Painful musculo-skeletal conditions  
 Contraindications: See package insert  
 Dosage: One tablet b.i.d. or q.i.d.  
 Supplied: Tablets

#### NEW DOSAGE FORMS

**SORQUAD Granucaps** Coronary Vasodilator Rx  
 Manufacturer: S. J. Tutag & Co.  
 Nonproprietary Name: Isosorbide dinitrate  
 Indications: Prophylactic therapy of angina pectoris  
 Dosage: One capsule every 12 hours  
 Supplied: Tablets, 40 mg

#### NEW USE OF OLD PRODUCT

**PROGLYCEM** Hyperglycemic Rx  
 Manufacturer: Schering Laboratories  
 Nonproprietary Name: Diazoxide  
 Indications: Hypoglycemia due to hyperinsulinism in various pathologic conditions  
 Contraindications: Functional hypoglycemia  
 Dosage: Must be individualized. Adults and children—3 to 8 mg/kg divided into two or three equal doses every 8 to 12 hours.  
 Supplied: Capsules, 50 and 100 mg.

**CORRECTION:** The August issue of IMJ included erroneous information regarding Synemol Cream. Synemol is manufactured only in 0.025% strength and in 15 gram and 60 gram tubes. It is not produced in 0.01% strength, or in jars, as formerly reported.

**SYNEMOL** Local Corticoid Rx  
 Manufacturer: Syntex Laboratories, Inc.  
 Nonproprietary Name: Fluocinolone Acetonide  
 Indications: Inflammatory manifestations of corticosteroid responsive dermatoses.  
 Contraindications: Vaccinia and varicella  
 Administration: Open therapy: Apply three or four times daily. Occlusive dressing: Leave visible coat on surface and cover with nonporous film.  
 Supplied: Tubes cream 0.025%, 15 gm. and 60 gm.

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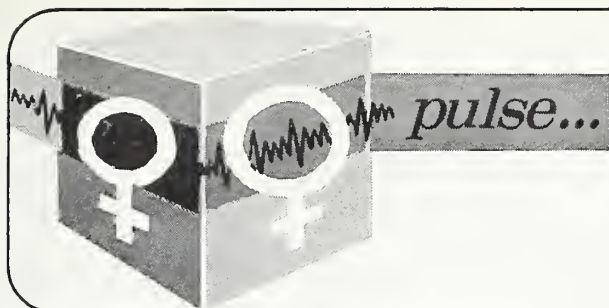
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## *pulse...* of the doctor's wife

Mrs. HAROLD KEEGAN, Editor

### *Patchwork II Fall Conference*

The second Patchwork Fall Conference was held Tuesday, September 28, 1976, at the Peoria Hilton Hotel. The conference was also the district meeting for districts 1, 1A, 2, 4, 5, 6, 7, 8, 9 and 10.

Mrs. John W. Ovitz, Jr., President of ISMS Auxiliary, called the conference to order and Dr. Robert DeBord, President of the Peoria County Medical Society, welcomed everyone to Peoria. Comments were heard from the President-elect and State Chairman. Mr. Robert Kjellander, Assistant Director of Governmental Affairs Division, ISMS, commented on the coming election and introduced Mary Lou (Mrs. Ronald) Sumner, an Auxiliary member who is running for state representative from Peoria.

The informative and interesting conference also included a demonstration on the Cardio-Pulmonary Resuscitation and the Abdominal Thrust (formerly the Heimlich Hug). John Pugh, Assistant Editor of the Peoria Star Journal, spoke in the afternoon.

Displays prepared by each chairman were enjoyed by all present, and the hospitality and graciousness of the Peoria Auxiliary were much appreciated. The efforts of Mrs. John E. Sheen, Fall Conference Chairman, and Co-chairmen Mrs. Donald Rager and Mrs. Robert Richardson, as well as the many other committee members from the Peoria Auxiliary, made this visit both rewarding and worthwhile.

### *Cook County Reorganization*

The Cook County Auxiliary has reorganized its branches into regional units. According to Anne Clemis, President of the Cook County Auxiliary, the change was effected to consolidate resources, expand and improve meetings and promote a united membership. The following coordinators have been appointed to implement the reorganization:

NORTH Unit (North Shore Branch, North West and Irving Park): Mrs. Herbert Cibul, 256-6789. SOUTH Unit (Southern Cook, Stockyards and South Chicago): Mrs. Conrad Urban, 335-1513. WEST Unit (Aux Plaines): Mrs. Abraham Schultz, 259-0860.



The Morgan-Scott County Auxiliary held their Bicentennial Luncheon at the DAR home on September 14, 1976. Standing in front of the house are (l-r) Mrs. Robert Kooiker, Morgan-Scott County Auxiliary President, Mrs. Edward Szewczyk, ISMS Auxiliary President-Elect, Mrs. John Ovitz, Jr., ISMS Auxiliary President, and Mrs. Robert Webb, ISMS Auxiliary 3rd Vice President.



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# THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

**Drug substitution** In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

**MAC** Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

**The drug lag** The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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2,500	18,242.23	35,854.56	66,772.78	111,758.57	177,212.50	272,447.35
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## Civic Responsibility



By the time this is published we will have elected a new Governor. We will be anticipating the appointment of new directors for the important state agencies which deal with health and welfare. The agencies, we know, will be more efficient and our working relationships with them we expect will be better. But mere optimism is not enough.

As citizens and as a professional society it is our responsibility to give the new executives concrete proposals for change wherever and whenever change is needed. One place to begin might be the mandatory continuing medical education law. The ISMS strongly approved this law but recently the Medical Examining Committee promulgated rules which make a mockery of its intent. Whether the Committee's actions stem from misunderstanding, ineptitude or prejudice is unimportant. What is important is getting the right regulations made. We, ourselves, should formulate regulations which carry out the intent of the law and present as a gift our carefully prepared regulations for the new Committee and we should not stop there.

In every area where regulations are unsatisfactory we should write specific proposals for change. Failure to present a set of workable and meaningful regulations will mean your leadership has failed you and that you have abdicated your responsibilities as citizens and as physicians.

*Joseph H. Skom, M.D.*

Joseph H. Skom, M.D.



# Doctor's News

**ALLERGY UPDATE**—In response to an item in the October IMJ Doctor's News, Dr. Robert J. Becker, President of the Illinois Society of Allergy and Immunology, has forwarded information regarding autogenous urine immunization. Dr. Becker warns Illinois physicians that the Academy's official position finds no rationale for the therapy, and has found no critical studies to support or recommend its implementation.

**INSURANCE NEWS**—John Patton, claims manager for the Insurance Services, advises caution with regard to a particular section of the newly passed Illinois malpractice legislation. Chapter 110, Section 21.1, allows a plaintiff, through his attorney, to name "John Doe" defendants for purposes of discovery, and later amend his complaint to name the doctor as a defendant in that litigation. In short, Patton warns, a doctor may be deposed without being named as a specific defendant in a case. If you should receive notice of an interrogatory or deposition, notify your insurance company and request legal assistance at the deposition. Members of the ISMS insurance program will receive this assistance without cost as a preventative measure, although the presence of an attorney will not guarantee immunity. The normal claim process will apply to those persons who may later become defendants.

**PRESIDENT'S TOUR**—ISMS president, Dr. Joseph Skom, has visited the medical societies of DuPage, Rock Island, Kane, St. Clair, Sangamon and LaSalle Counties in the first portion of his President's Tour. He plans to visit the Jefferson-Hamilton County Medical Society on November 18, the DeKalb Medical Society on November 23, and the Morgan-Scott Medical Society on December 7. The 1977 President's Tour dates will be announced in a forthcoming issue of IMJ.

**CHIROPRACTIC INFORMATION**—A brochure and newspaper advertisements have been published, encouraging people to call "Chiro-Tel" for information regarding chiropractic treatment. The toll-free in-WATS number, 800-634-6541, carries messages explaining how chiropractic can relieve such ailments as arthritis, ulcers, allergies and hypoglycemia.

**LICENSE RENEWALS LAG**—Information from the Department of Registration and Education indicates that 19,632 physicians listing Illinois addresses were licensed prior to July 1, 1976, the most recent license renewal date. At the end of September, 2,251 Illinois physicians had not applied for license renewal. While some of these may be attributed to physicians retiring from practice, 11% is a figure higher than usual. Physicians still engaged in the practice of medicine who have not renewed their licenses, for whatever reason, are urged to apply to the Medical Licensure Section, Department of Registration and Education, 628 E. Adams, Springfield, 62786.

**MEDICAL-LEGAL UPDATE**—An amendment to the Illinois statute relating to inspection of hospital records (P.A. 79-1434) grants former hospital patients the right to inspect and receive a copy of their medical records. The amendment, which became effective September 19, 1976, provides that the patient's request be made in writing to the hospital, and a recent Appellate Court decision has ruled that hospitals do not have to furnish the record without charge.

**1977 TRAVEL PROGRAM**—As a membership service the following travel programs will be offered in 1977:

February 1-14: **SOUTH AMERICAN ADVENTURE** (Caracas, Rio De Janeiro, Lima)

June 28-July 11: **SOUTHERN EUROPEAN ADVENTURE** (Lausanne, Florence, Nice)

September 5-October 9: **AROUND THE WORLD ADVENTURE**

September 23-October 6: **GREEK ISLES-BLACK SEA AIR/SEA CRUISE** (Athens, Greek Isles, Dikili, Odessa, Yalta, Sochi, Istanbul)

October 14-23: **LONDON-ROME DISCOVERY**

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without using the official form printed in these brochures. Persons outside a member's immediate family will be placed on a standby status until all ISMS members have had a reasonable time for making reservations. All promotional expense connected with these programs is paid by the tour operator. Contact Perry Smithers or Betty Duffy at ISMS headquarters for details.

**PHYSICIANS IN THE NEWS**—Six Illinois physicians have been named to serve on the newly created 53 member Statewide Health Coordinating Council, which replaces the Comprehensive Health Planning Advisory Board as the primary health planning and policymaking body for the state. Board members, who will help to determine a statewide plan for health services, include **Henrietta Herbolsheimer, M.D., Ph.D.**, University of Chicago, **B. Smith Hopkins, Jr., M.D.**, Urbana, and **William Kabish, Ph.D.**, Springfield, who is a member of the Illinois Cancer Council and a professor at the SIU School of Medicine. **Dr. Mark Lepper**, Vice President of the Rush-Presbyterian-St. Luke's Medical School, **Dr. Leroy Levitt**, director of the Illinois Department of Mental Health and Developmental Disabilities and **Dr. Hugh Rohrer**, a Peoria public health physician, also will serve on the board.

Upon leaving his post as Director of the Department of Mental Health and Developmental Disabilities on December 1, **Dr. LeRoy P. Levitt** will become chief medical administrator at Mount Sinai Hospital Medical Center and also will be a Professor of Psychiatry at Rush Medical College. Dr. Levitt's position was created by the Hospital Governing Board to encompass a wide range of responsibilities designed to strengthen the teaching affiliation of Mount Sinai Hospital to the Rush-Presbyterian-St. Luke's Medical Center and also expand the health delivery system now provided by the hospital. Dr. Levitt will also supervise all undergraduate and graduate teaching for Mount Sinai hospital.

Many new appointments have been announced in Illinois health care within the last month. These include: **Dr. Frank W. Fitch** as Associate Dean for Medical and Graduate Education at the University of Chicago Division of Biological Sciences and Pritzker School of Medicine; **Dr. Julius M. Kowalski**, Princeton, Clinical Assistant Professor at the University of Illinois College of Medicine in Peoria; **Dr. Jan Steiner** as Director Designate of the Illinois Cancer Council; **Marvin Hirsch, D.M.D.**, as Director of the Maxillofacial Prosthetics Clinic at the University of Illinois Hospital and also Assistant Professor of Maxillofacial Prosthetics in the Department of Otolaryngology at the Abraham Lincoln School of Medicine; and **Dr. Robert J. Stein** as the first Medical Examiner for Cook County. The position of Medical Examiner was instituted to replace that of County Coroner.



## MEN OF MEDICINE, 1776-1976

# An Illinois Surgeon's Training At the Start of this Century

BY FRANCIS H. STRAUS, M.D./CHICAGO

I was born in Chicago in 1895. With one exception, I had no medical contacts until I returned in February of 1919, clutching a newly acquired M.D. The exception remains vividly in my memory.

My parents then lived on Dearborn street, a few doors away from the home of Nicholas Senn. His gray haired coachman would sit patiently behind a team of good horses waiting to drive Dr. Senn to the Presbyterian hospital. I had many long conversations with the coachman, who was kind to a four-year-old boy, but discussion could be terminated in midsentence when the vigorous, middle-aged Senn hastened down the steps of the Victorian front stoop and climbed in beside his driver.

My medical education at an eastern school had been accelerated to graduation by working through two summers. The first world war was in progress, increasing the need for young physicians. I came to Chicago to seek my medical fortune.

February, 1919, was an inauspicious time to seek an internship. Those appointments were synchronized with the academic year and started in July, in order to take in newly graduated senior students. Internship was not then a prerequisite to medical licensure in Illinois, or, I believe, elsewhere. But it was becoming an important asset. In Chicago the medical schools were ahead of the state registration regulations, and did not grant the M.D. degree until a year of internship had been completed. Although I

had the degree which permitted me to take the state boards and become licensed, I still felt an internship might be desirable.

There was an interesting sidelight on the war-time acceleration. During the summer of 1918, an eminent professor of neuropsychiatry sent for me and said: "Straus, do you want to be a neurosurgeon? There are only five neurosurgeons in the country and four of them are in France. The remaining one is Frazier in Philadelphia. He is giving a six week rapid training course in neurosurgery. There is great need for such men, and after that course, you can go at once to France as a neurosurgeon."

After very little thought I decided that the proposal was impractical. This was fortunate, as the war ended even before I would have become a six week neurosurgeon.

Left with my degree, but out of step with the internship cycle, I talked with Dr. Arthur Dean Bevan, who offered me a residency in surgery in the Presbyterian Hospital. The residency could begin after I had completed an internship elsewhere. Dr. Bevan arranged that I could have a surgical internship at Barnes Hospital with Dr. Evarts Graham.

Graham had been trained by Bevan and had made a brilliant record as a member of Moscovitz Commission, which clarified the then chaotic methods of treatment of the huge numbers of thoracic empyemas resulting from the 1917-18 influenza epidemic. Dr. Graham was to go to Barnes as chief of surgery in July of 1919, and

I was to go there as the low man on the totem pole.

In the meantime, I spent several happy and industrious months as a substitute intern in the Michael Reese Hospital. Fortunately my senior intern there was not at home in surgery, and allowed me to take over much of the responsibility and most of the actual surgery which might be handed to an intern. The corollary was that I became too big for my breeches, but it took little time for Barnes and Dr. Graham to show me that I still had a long way to go.

Barnes was very hard work, strictly disciplined, with a seven day week and a twenty-four hour day. The remuneration was room and board and an assortment of hand-me-down white uniforms. During that winter I once spent thirty-one days without leaving the hospital buildings. The natural result was a rather severe respiratory infection. In later years I could recall with some pleasure that I had called in Warren Cole and Alton Ochsner during the postmidnight hours to work up emergency admissions. They were senior medical students at Washington during that year.

In September of 1920 I returned to Chicago and the Presbyterian Hospital residency. Their distinguished staff and faculty were one and the same. Frank Billings was about to retire as chief of medicine. James Herrick and Bertram Sippy were very active with large hospital services and a cloud of younger associates. Phemister and Vernon David were promising young men. Chicago surgery just previous to this period had been dominated by Bevan, Ochsner and L. L. McArthur. John B. Murphy had been a great figure, but he had died.

Also at Presbyterian Hospital, Rollin Woodyatt pursued his solitary and introspective work in the laboratory, and treated large numbers of diabetics. During this period Woodyatt developed and used a "beer colored pancreatic extract" which had the remarkable property of reducing blood sugars and controlling diabetic acidosis. This was, of course, a crude insulin. (Banting's publication appeared and Woodyatt never claimed any credit, although I believe his method of extracting insulin is still used by the pharmaceutical houses.)

When I came to the Presbyterian Hospital I was the only resident there in any discipline. The concept of residency training was fairly new and there were not many such positions in the country. Most specialty training was still being done under an informal preceptorship and association with an older and distinguished

man.

I had had a predecessor resident at Presbyterian Hospital who had been retained in his residency for some eight years, and had become a very able man in his own right. This was largely because the recently terminated first world war had interrupted the staff plans. By the third year of my residency there were two more residents in surgery, and they were rapidly followed by residents in other disciplines.

But at outset I was the solitary resident, and this afforded me one great advantage. I was somewhat older and more experienced than most of the intern house staff, and became an unofficial consultant to interns in many other disciplines. Although I was not a very adequate consultant, this exposed me to many problems in medicine other than surgery. This has been, I believe, very useful to me throughout my life, even if it was not most useful to the patients involved.

My first assignment other than the clinical responsibility for patients and assistance at operations was accountability for all the surgical pathology reports of the hospital. As I had had only the rudimentary medical student's training in this before, I had to become an instant surgical pathologist. It was a grueling time but I have never regretted it.

Teaching responsibilities were almost immediate. I first taught "Principles of Surgery, Surgical Anatomy on the Cadaver," and what were called "ward walks" with senior students. At one time, Dr. Lester Dragstedt had been scheduled to give a lecture course in "Surgical Physiology." This was a new type of course and Dragstedt had a very good background as a physiologist. However, he became ill and could not initiate the course. The finger was put on me, and I became an overnight physiologist. In all these efforts I had to keep just one jump ahead of my students. It was an excellent education for me. Later, I repeated the same course for many years. I was able to vary its content from year to year and I am sure I learned much more from the exercise than did my students.

I attained what little operative surgery I could when my chiefs were unavailable. During the summer I was sometimes given responsibility for the "Big Clinic." This was a lecture course which was supposed to cover the bases of regional general surgery. As an added emolument the assignment carried responsibility for the so-called "service cases" which were admitted from the Central Free Dispensary for free surgical care. Those were big moments, but they were rare and occasional.



All things end, and so did my three year residency. It had been both a monastic and an ascetic period. Although I had learned a great deal, I finished my supposed training with the knowledge that I was yet only half formed.

Fortunately this was remedied when Dr. Bevan offered the opportunity to become his personal associate. I was able to have patients of my own as well as assist him with his large practice. I was even thrown crumbs from his table in the form of his less interesting or less important patients. I could continue to teach.

At about this time, in 1924, I married Elizabeth Kales, the great granddaughter of Nathan Davis. She was a medical student when we married, but her recollections of the doctor might bring a fitting conclusion to this account of early medical education in Illinois.

Davis had been educated in Elmira, New York. He was induced to come to Chicago and teach in what was then Rush Medical College. He did so, but soon became critical of the curriculum and attempted to inculcate his ideas with the faculty.

The degree course was then two years long. High school graduation was a prerequisite to admission. The first year consisted in a course of lectures. The second year consisted in repeti-

tion of the same series of lectures. Davis believed it desirable to offer the students a somewhat different, or at least advanced, series of lectures in their second year. He could not convince his faculty of this, and left Rush to help found the medical school at Northwestern University adopt this radical innovation.

Davis had had all of his teeth extracted early in life under some earlier belief in what later became Frank Billing's theory of focal infection. Not only was he instrumental in the founding of the American Medical Association, but he was an early advocate of White's later notion concerning the value of consistent exercise for the elderly heart. This has eventuated in the current fad of jogging.

Elizabeth Kales had known her great grandfather well. He lived until she was old enough to pick violets for the very old man's coffin. She remembers him as a puritanical old man who was very kind to her, but of whom she was quite afraid.

One of Elizabeths earliest memories is of riding in a sleigh from the North Side, bundled up against the cold, beside the driver. She recalls her aged great grandfather's dog trotting behind as they journeyed to make his rounds at Mercy Hospital. ◀

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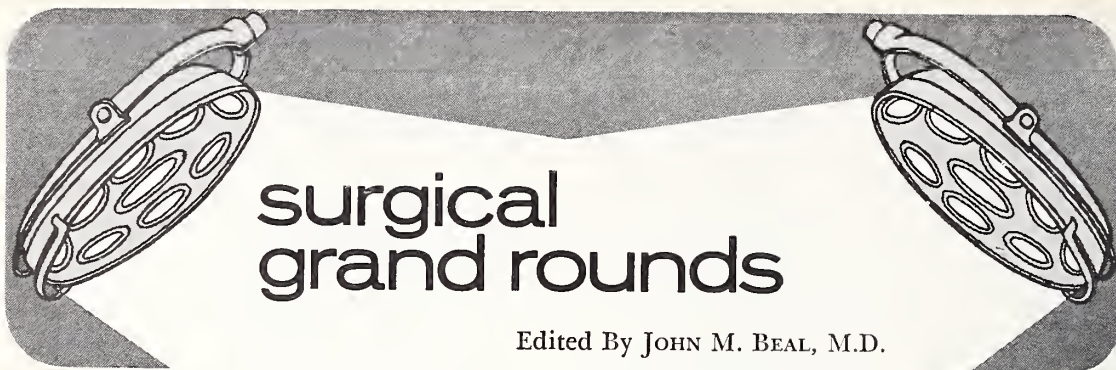
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*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of July 6, 1976.*

## Case Report: Summary of Surgical Infections — 1975

**Dr. Boris Reisberg:** This discussion will consider some of the problems with surgical infections this afternoon, present a broad assessment of the problems and give consideration to means to decrease the rate of hospital infection. Much of the data is based on the annual report of the Infections Surveillance Committee for 1975 for the Northwestern Memorial Hospital.

When I come to Surgical Grand Rounds, I feel that I must reassure the surgeons and indicate that the rate of infection for the medical service is approximately the same as the surgical rate of infection. Both have their own problems with nosocomial infections. For the past several years when statistics have been kept, the overall rate of infection has been approximately 4.5% for all patients admitted to the hospital, regardless of the reason for that admittance.

The rate of infection on the general surgical service in 1975 is presented in Table I. In 1975, approximately 4,000 general surgical patients were discharged. Of these, there were 106 different wound infections, about two-thirds of which occurred in "clean-contaminated" or contaminated-type operations, and 44 infections occurred in patients who had clean operations, that is, a viscus was not entered, drainage was absent, and gross contamination at the time of

operation or break in surgical technique did not occur. Following closely in incidence were urinary tract infections. Respiratory tract infections are more difficult to document simply because the differential diagnosis of fever and of pulmonary infiltrate in a postoperative patient is very wide, and criteria for the designation of pneumonitis is fairly rigid. There were only 27 patients that would meet all the criteria; that is, physical findings, X-ray findings, fever, and a notation by the physician that the patient had pneumonia rather than pulmonary embolus, atelectasis, or an effusion of other etiology.

**Table I**  
**Wound Infections (Hospital-Associated)**  
**By Service—1975**

	No. of Patients	Surgical Wound		Total
		Clean	Clean-Contaminated and Dirty	
General Surgery	3975	44	62	106
Orthopedics	2431	29	7	36
Urology	1079	3	21	24
Otolaryngology	2710	1	14	15



Bacteriemia occurred in 28 patients on the surgical service who were free of infection at the time of admission and in whom infection developed subsequently.

Finally, there were eight cases of intravenous catheter infections in which there was a documentation of pus and inflammation at the site of the catheter. Of all sites, including peritonitis which was not included in wound infection, a total of approximately 300 infections occurred with an overall infection rate of 7.4 percent. It should be noted that some patients had more than a single infection which influences this figure.

Two specific points will be considered next: a) how common is infection in certain operations and b) what are the microorganisms most commonly associated with these infections. These pertain not only to wound infections but also infections of the respiratory tract, the urinary tract, and bacteriemia.

### Incidence and Nature

There were 187 patients who had bowel resection in 1975. Among these, 20 wound infections occurred, or 10.7% (Table II). The organism most commonly isolated in wound infections when the operative procedure was a bowel resection was *E. coli*, followed by *Proteus mirabilis*, and *Klebsiella*. Five patients had *Bacteroides fragilis* isolated from their wounds, which was found because of improved culture techniques. Ten of 187 patients had a documented bacteriemia following bowel resection (5.3%). Blood cultures were taken usually because of the presence of fever or signs of sepsis. Again, almost exclusively gram negative organisms were isolated—*E. coli*, *Klebsiella*, *Streptococcus faecalis*. One patient had *Bacteroides fragilis* isolated from a blood culture. These are similar to the organisms which were cultured from the wound infections and similar to the organisms present in the stool.

Thirteen patients had urinary tract infections, a fairly high rate of urinary infection when compared to other surgical procedures where urinary tract infections have been monitored. This is related to the frequent use of the Foley catheter and the length of time that it is left in the bladder. *Pseudomonas* was the most common organism and was present in six of the urinary infections, with *E. coli* in four patients and *Streptococcus faecalis* in three. The high rate of *Pseudomonas* is perhaps a reflection of selection pressure by antimicrobial agents.

The total number of patients who had infections were 35 (18%). This infection rate is not excessive when one considers the extent of the resections, the debilitation of the patient and the associated diseases.

The infection rate in cholecystectomy offers a marked contrast. Wound infections occurred in only five patients (2.1%). The predominating organisms were *Klebsiella* and *Staphylococcus aureus*, which is now the second most common organism present in a wound infection in gallbladder surgery. At Northwestern Memorial Hospital last year, among the "clean" cases, *Staphylococcus aureus* accounted for approximately 30% of all wound infections, while in the contaminated and "dirty" cases, *Staphylococcus aureus* accounted for only 20%. Bacteriemia occurred on three instances in cholecystectomy, *Staphylococcus aureus*, *Bacteroides fragilis*, and *Streptococcus faecalis* each in one instance. *Streptococcus faecalis* is an often ignored bacteria both by the medical journals and by most conferences that deal with infection. It is an organism prominent in fecal flora and may be one of the first organisms to produce or initiate an infection. It has the capacity to provide the local milieu for other facultative and anaerobic organisms to subsequently multiply. So, if the wound or abscess is cultured late, *Streptococcus faecalis* may not be found, but it is an excellent "helper" organism and one that provides local conditions necessary for more obligate anaerobes to grow.

### Wound Infections

The following remarks will deal with basic consideration in wound infections and the mode of spread of infections that are hospital acquired.

I would like to start with the genesis of wound infection. Perhaps the most important concept that has been published in the recent literature is the observation that for a wound to become infected, there must be a minimal number of organisms present. Every operative surgical

Table II  
Wound Infection After Bowel Resection—1975

BOWEL RESECTIONS	187
WOUND INFECTIONS	20 (10.7%)
<i>E. coli</i>	11
<i>Proteus mirabilis</i>	7
<i>Klebsiella</i>	5
<i>Bacteroides fragilis</i>	5
<i>Pseudomonas</i>	4
Others	13

wound is contaminated with microorganisms of some sort, even if just from the skin. One cannot sterilize the skin with surgical antiseptics or germicides. In my opinion, the customary practice of shaving the patient the night before the operative procedure rather than the morning of the procedure is undesirable. Several studies have demonstrated a marked increase in the number of skin organisms. Shaving immediately before the operation is much better.

For a long time, it has been known that inoculum size is critical. Classical experiments have shown that to produce a skin pustule in a normal, healthy individual, approximately  $7.5 \times 10^6$  staphylococci or slightly over a million staphylococci are required for this infection to occur. In the presence of a foreign body such as a suture, the number of organisms needed to produce the same pustule can be reduced 10,000 fold.

Recently, studies have been carried out utilizing quantitative wound cultures. In other words, the wound is actually biopsied at various points during a surgical procedure, the tissue is ground up and the bacteria are enumerated quantitatively. Approximately 100,000 organisms or  $10^5$  organisms are required for most patients to develop a wound infection at the operative site. Most of the contamination occurs during the operative procedure or very shortly thereafter. Whether patients whose host defenses are diminished would require  $10^5$  organisms at the site of the surgical wound to subsequently develop a wound infection has not been studied adequately. These quantitative cultures have been particularly useful in skin grafting. If one has an area of granulation tissue and wants to cover this with a skin graft, for example, after a burn, if that site on biopsy has  $10^5$  organisms or more, there is only approximately a 16 per cent chance that the graft will take. If the biopsy site has less than that number of organisms, the chances of the graft taking are approximately 90%.

Quantitative wound culturing has added to our understanding of the mechanism of the development of operative wounds. Therefore, if one is dealing with a contaminated area such as a perforated appendix with peritoneal exudate containing greater than  $10^5$  organisms, the possibility of wound infection is far greater than with simple non-perforated appendicitis.

In terms of recognition and therapy of wound infections, a word of caution is warranted about an organism that appears occasionally, Group A Streptococcus. This organism is still capable of producing fever within 24 hours of the opera-

tion. One must be aware that an occasional patient will have Group A Streptococcal infection which may be absolutely devastating in terms of morbidity. I recently reviewed a case from another hospital where a patient had a simple herniorrhaphy and 24 hours after operation developed a temperature to  $103^\circ$  F. He was thought to have atelectasis and IPPB was instituted. The next day, his temperature rose to  $106^\circ$  F. and blood cultures were now positive for Group A Streptococci. The patient almost succumbed to this very virile infection, something we seldom encounter, but must continue to remember.

More wound infections are being converted from the customary enteric organism to more esoteric bacteria, such as *Pseudomonas* and *Serratia*. Conversion of open wounds occurring during hospitalization can happen by either of two mechanisms: 1) the patient can contaminate the wound by himself; or 2) by exogenous bacteria brought to the patient by physicians, nurses, and/or other ancillary personnel. My plea is that all of us, both in medicine and in surgery, to respect the very basic principles of aseptic technique. Our failure to wear gloves when wounds are being dressed, and to wear the appropriate garb contribute to this. Most crucial are the gloves and second in importance is the mask. When a wound becomes infected, organisms multiply rapidly at skin temperature. If the dressings of an infected wound are picked up by bare hands, the hands become contaminated, and the possibility of cross-contamination has been greatly increased.

### Other Problem Areas

The second group of infections I would like to discuss are pulmonary infections. Postoperative pulmonary infections are the most ignored, perhaps the least well studied, and the most difficult to document. Sputum cultures in patients who develop pneumonia in the hospital while receiving antibiotics are often of little value. The only way one can obtain an adequate culture is by translaryngeal aspiration. That is a more appropriate mechanism for obtaining material for culture because pneumonia occurring in the postsurgical patient is aspiration pneumonia. In addition, one can obtain both aerobic and anaerobic cultures by this method.

Urinary tract infection is straightforward. I think we must try to get the catheter out as quickly as possible and not leave it in for convenience. When we make rounds, we ought



to think of the Foley catheter as frequently as we consider when to remove the nasogastric tube.

Finally, there are infections associated with the intravenous catheters. On the surgical service, there were eight so documented infections. By "so documented"—and the number is low, there had to be gross pus at the site of involvement. The possibility of infection in the area, for instance, that was recorded as phlebitis was not recorded as an infected intravenous site. We are very strict in our definition of infected catheter sites. Obviously, there are areas of infection that were missed when we record only eight documented infections at intravenous catheter sites on our whole surgical service. In the hospital as a whole, there were 29 intravenous catheters that were infected, and eight cases of Bacteriemia secondary to intravenous catheter usage. That means that approximately one out of every four patients that develops an infection in association with an intravenous catheter will have Bacteriemia. Most of the time this is self limiting if you are dealing with gram negative rods. Our policy for treatment of patients that have staphylococcal bacteriemia from an intravenous catheter site is ten days of intravenous antibiotic. This appears to be adequate from the only study published in the literature to prevent the development of serious metastatic staphylococcal infection.

I think we have done exceptionally well with the number of infections that are associated with hyperalimentation. We have had no instances of fungal infections in this hospital associated with our hyperalimentation and I think this is excellent.

### Recommendations

In specialized care areas, spread of infection among the hospitalized patients is probably due to personnel, and primarily due to contamination from hands. If one traces urinary tract infections in such units, the "classical" development of urinary tract infections results from organisms in the stool, which gain access to the tip of the catheter, then into the bladder and thus the resultant infection. Can hospital acquired infections occur by other mechanisms? The answer is, yes, and it is passage by personnel from patient to patient. We have documented that most patients with Foley catheters in the same room develop urinary tract infections with the same bacteria. An excellent example of this was seen in a group of patients on the same hospital ward whose stools were free of *Serratia*; all developed urinary infection with this bacterium. It was observed that the

Foley catheters were manipulated three or four times daily for urinary collections and measurement. Every time the drainage system was emptied, or a sample obtained, a potential break in technique occurred.

The only way that this chain of hospital-acquired urinary tract infection in closed or multiple bed units where Foley catheters are used frequently can be broken is to insist on gloved technique. Why glove technique rather than hand washing? The reason is two-fold. One is that it is very difficult to have compliance with hand washing when dealing with a multitude of personnel, including nurses, aides, physicians, and ancillary personnel of all sorts. Two is that we are dealing with hospital acquired infections in 1976 that are predominantly gram negative. Hand washing using soap, PhisoHex, or Betadine is not very effective in reducing the number of gram negative organisms on our hands. They are excellent against staphylococci or gram positive bacteria. Therefore, if you are attempting to break the spread of gram negative infections from patient to patient, the only thing you can insist upon is glove technique. ◀

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# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## December, 1976

### Burns

#### TREATMENT OF MINOR TO MODERATE BURNS

For: Physicians and Nurses. Symposium. Dec. 8, 9:00 AM-2:00 PM. Mother Leonarda Hall, St. Therese Hospital, Waukegan. **Speaker:** Alan Dimick, M.D., Asso. Prof. of Surgery, Univ. of Alabama. **CME Credit:** 5 hrs. AMA Cat. 1; AAFP Elective; Illinois Nurses Asso. Reg. Deadline: Dec. 7. **Sponsor, contact:** St. Therese Hospital, 2615 W. Washington, Waukegan, IL 60085. Telephone: (312) 688-6461. Attn: R. M. Adelman, D.D.S., M.D. Co-Sponsors: R. M. Adelman, D.D.S., M.D. and Marguerite Turpel, R.N.

### Family Therapy

#### PROBLEM-CENTERED FAMILY THERAPY

For: Physicians and Mental Health Professionals. Two day Workshop. Thursday, Dec. 2 and Friday, Dec. 3, 9:00 AM-4:30 PM. Chicago, IL. **Speaker:** William Pinsof, M.A. F.I.C./C.F.S. staff, Chicago. **CME Credit:** 14 hrs. AMA Cat. 1. Fee: \$60. Reg. Limit: 50. **Sponsor, contact:** The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

### Family Medicine

#### CURRENT CONCEPTS IN THE TREATMENT OF EPILEPSY

For: Physicians. Lecture. December 7, 8:00 PM. Sherman Hospital, Elgin. **Speaker:** Sandra Jane F. Olson, M.D., Northwestern Medical School. **CME Credit:** 2 hrs. AMA Cat. 1. Fee: None. **Sponsor, contact:** Sherman Hospital, Continuing Medical Education Comm. (Dr. Walter Gasser, Chm.), 934 Center St., Elgin, IL 60120. Attn: Mrs. Mary Anne Stiege-meier. Telephone: (312) 742-9800, ext. 649.

### Internal Medicine (Cardiology)

#### PERICARDITIS AND CHEST PAIN

For: Physicians, Residents, Interns. Lecture. December 1. Martha Washington Hospital, Chicago. **Speaker:** Alfred Soffer, M.D., Editor-in-Chief of the Journal, Chest; Executive Director, American College of Chest Physicians. **CME Credit:** 1 hr. AMA Cat. 1; AAFP Prescribed. **Sponsor, contact:** Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618. Attn: Fernando Villa, M.D., Medical Director. Telephone: (312) 583-9000 ext. 331.

### Internal Medicine (Nephrology/Renal)

#### FLUID & ELECTROLYTE BALANCE, HYPERTENSION & RENAL DISEASE

For: Practicing Internists and General Practitioners. 5-day postgraduate course. Dec. 6-10, 9:00 AM-5:00 PM daily. Northwestern Memorial Hospital, Chicago. **CME Credit:** 22 hrs. AMA Cat. 1; AAFP Prescribed. Fee: ACP Members, FACP, Residents \$140; Non-Members \$200; ACP Associates \$70. **Sponsor, contact:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. Telephone: (215) 243-1200 ext. 220. Attn: Linda M. Salsinger, Registrar. Co-Sponsors: Northwestern Univ. Medical School and Northwestern Memorial Hospital.

## Primary Care

### ISSUES IN PRIMARY CARE

For: Physicians, Nurses, Hospital Admin., Insurance Providers. Workshop. Dec. 3. 8:00 AM-5:00 PM. Continental Plaza Hotel, Chicago. **CME Credit:** 7 hrs. AMA Cat. 1; Cat. 2. Fee: Institute Fellows \$40; Non-members \$45 (includes lunch). **Sponsor:** The Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago 60604. **Contact:** Louis B. Kuhn of the Julian J. Jackson Agency, 919 N. Michigan Ave., Chicago 60611. Telephone: (312) 944-5144.

### Otolaryngology and Maxillofacial Surgery

#### SYMPOSIUM ON BASIC PROBLEMS IN OTOLARYNGOLOGY AND MAXILLOFACIAL SURGERY

For: Internists, General Practitioners, Family Practitioners, Pediatricians, and Otolaryngologists. Symposium. December 10, 8:15 AM-5:00 PM. Rehabilitation Institute, Chicago. **CME Credit:** 6½ hrs. AMA Cat. 1. Fee: \$60. Reg. Limit: 135. **Sponsor:** Dept. of Otolaryngology and Department of Postgraduate Education in conjunction with the Ill. Head and Neck Cancer Network. **Contact:** Jacob R. Suker, M.D., Associate Dean, Graduate and Postgraduate Education, 303 E. Chicago Ave., Ward 4-334, Chicago, IL 60611. Telephone: (312) 649-7947.

### Psychiatry

#### UNDERSTANDING PEOPLE THROUGH TRANSACTIONAL ANALYSIS

For: Mental health care professionals. Lecture. Dec. 15, 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker:** Thomas Harris, M.D., Author of "I'm OK, You're OK . . ." **CME Credit:** 3 hrs. AMA Cat. 1. Fee: \$10. Reg. Limit: 200. Reg. Deadline: Reservations (771-7000 ext. 342). **Sponsor, contact:** Riveredge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations. Telephone: (312) 771-7000 ext. 305.

#### PERSPECTIVES IN LAW AND PSYCHIATRY

For: Psychiatrists. Distinguished lecture series. Dec. 15, 8:00 PM. Offield Auditorium, Passavant Hospital, Chicago. **Speaker:** Irwin Perr, M.D., Prof. of Psychiatry, Rutgers Med. School. **CME Credit:** 1½ hrs. AMA Cat. 1. Fee: None. **Sponsor, contact:** Institute of Psychiatry, 320 E. Huron, Chicago 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058. Co-sponsor: Northwestern Univ. Med. School.

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## January, 1977

### Family Therapy

#### A DAY WITH MURRAY BOWEN

For: Physicians and Mental Health Professionals. One-day workshop. Friday, Jan. 21, 9:00 AM-4:30 PM. **Speaker:** Murray Bowen, M.D., Georgetown Univ. Hospital, Washington, D.C. **CME Credit:** 7 hrs. AMA Cat. 1. Fee: \$35.00. **Sponsor, contact:** The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-Sponsor: Northwestern Memorial Hospital and Northwestern University Medical School.

### Internal Medicine

#### THE YEAR IN INTERNAL MEDICINE

For: All internists and family practitioners. Postgraduate course. January 19, 20 and 21 (9:00 AM-5:30 PM). Northwestern Memorial Hospital, Passavant Pavilion, Chicago. **CME Credit:** 21 hrs. AMA Cat. 1; AAFP prescribed. Fee: \$125. Reg. Limit: 110. **Sponsor:** Northwestern University Medical School and Northwestern Memorial Hospital. **Contact:** Jacob R. Suker, M.D., Associate Dean, Postgraduate Education, 303 E. Chicago Ave., Chicago, IL 60611. Telephone: (312) 649-7947.

### Psychiatry

#### PERIPATETIC QUEST FOR KNOWLEDGE

For: Professionals and Students in the Health Field. Lecture. Jan. 12, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. **Speaker:** Shervert Frazier, Jr., M.D., Harvard Univ. **CME Credit:** 2 hrs. AMA Cat. 1. Fee: \$15 prof., \$5 student. Reg. Limit: 100. Reg. Deadline: advance registration requested. **Sponsor, contact:** Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D. Telephone: (312) 827-8811.

#### SCHIZOPHRENIC COMMUNICATIONS

For: Mental health care professionals. Lecture. Jan. 19, 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker:** Gregory Bateson, Senior Lecturer, Kresge College Univ. of Cal. **CME Credit:** 3 hrs. AMA Cat. 1. Fee: \$10. Reg. Limit: 200. Reg. Deadline: Reservations (771-7000 ext. 342). **Sponsor, contact:** Riveredge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations. Telephone: (312) 771-7000 ext. 305.

#### ETHICAL DISCIPLINE IN THE APA

For: Psychiatrists. Distinguished guest lecture series. Jan. 19, 8:00 PM. Offield Auditorium, Passavant Hospital, Chicago. **Speaker:** Robert A. Moore, M.D., Chairman, Comm. on Ethics, Amer. Psychiatric Asso. **CME Credit:** 1½ hrs. AMA Cat. 1. Fee: None. **Sponsor, contact:** Institute of Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago. Attn: Jeanne Smith. Telephone: (312) 649-8058.

### Radiography

#### QUALITY ASSURANCE EVALUATION OF THE RADIOGRAPHY DEPT.

For: Administrators or Radiologists. Lecture and Workshop. January 6, Cook County Graduate School of Medicine, Chicago. **Speaker:** Walid F. Hinde, M.D. (Coordinator). **CME Credit:** 24 hrs. AMA Cat. 1. Fee: \$125. Reg. Limit: 75. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60667. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.



*Pediatrics*

**SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY**  
For: Surgeons (Prep. for Board). Lecture, Feb. 14 (5 days). Cook County Graduate School of Medicine, Chicago. **Speaker:** John Raffensperger, M.D. (Coordinator). **CME Credit:** 38 hrs. **AMA Cat. 1. Fee:** \$200. **Reg. Limit:** 150. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

*Psychiatry*

**MARRIAGE WITHOUT WALLS**  
For: Professionals and Students in the Health Field. Lecture, Feb. 2, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. **Speakers:** Samuel Janus, Ph.D., and Barbara Bess, M.D. both of New York Medical College. **CME Credit:** 2 hrs. **AMA Cat. 1. Fee:** \$15 prof.; \$5 students. **Reg. Limit:** 100. **Reg. Deadline:** advance registration requested. **Sponsor, contact:** Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D., Director of Medical Education. Telephone: (312) 827-8811.

**THE MIND-BODY RELATIONSHIPS IN ILLNESS AND HEALING**  
For: Mental health care professionals. Lecture, Feb. 16, 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker:** Jerome D. Frank, M.D., Johns Hopkins U. School of Medicine, Baltimore. **CME Credit:** 3 hrs. **AMA Cat. 1. Fee:** \$10. **Reg. Limit:** 200. **Reg. Deadline:** Reservations 771-7000 ext. 305. **Sponsor, contact:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations. Telephone: (312) 771-7000 ext. 305.

**TECHNIQUES OF LEGISLATIVE INFLUENCE**  
For: Psychiatrists. Distinguished lecture series, Feb. 16, 8:00 PM Offield Auditorium, Passavant Hospital, Chicago. **Speaker:** Robert J. Campbell, M.D., Chairman, APA Commission on Legislation. **CME Credit:** 1½ hrs. **AMA Cat. 1. Fee:** None. **Sponsor:** Institute of Psychiatry-Northwestern University Medical School. **Contact:** Institute of Psychiatry, 320 E. Huron, Chicago, IL 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058.

*Surgery*

**REVIEW COURSE IN NEUROLOGICAL SURGERY**  
For: Neurological Surgeons. Lecture, Feb. 4 (10 days). **Speaker:** Leonard I. Kratzler, M.D. (Coordinator). **CME Credit:** 95 hrs. **AMA Cat. 1. Fee:** \$400. **Reg. Limit:** 200. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**SPECIALTY REVIEW COURSE IN THORACIC SURGERY**  
For: Surgeons. Lecture, Feb. 21 (5 days), Cook County Graduate School of Medicine, Chicago. **Speaker:** Constantine Tatoes, M.D. (Coordinator). **CME Credit:** 40 hrs. **AMA Cat. 1. Fee:** \$200. **Reg. Limit:** 200. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

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*Centralia*—Oct. 20, Nov. 3, 17.

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*Chicago Nearwest*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Chicago North*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

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*Hinsdale*—Oct. 27, Nov. 10, Dec. 1.

*Melrose Park*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Park Ridge*—Oct. 20, 27, Nov. 3, 10, 17, Dec. 1.

*Peoria*—Oct. 21, Nov. 4, 18.

*Rockford*—Oct. 28, Nov. 11, Dec. 2.

*Rock Island*—Oct. 21, Nov. 4, 18.

*Springfield*—Oct. 26, Nov. 11.

For details of time and place, contact: Illinois Academy of Family Physicians, 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604. Telephone: (312) 427-5314.

**Have You Seen the New Illinois Mandatory CME Law?**

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## report

Illinois Society  
American Association of Medical Assistants

# Medical Assisting Education

## New Programs and New Graduates

The medical assisting programs of two Illinois colleges have recently received accreditation by the Council of Medical Education of the American Medical Association, in conjunction with the Curriculum Review Board of the American Association of Medical Assistants. These programs, at Triton College, in River Grove and William Rainey Harper College, in Palatine, also offer the opportunity to obtain an associate degree in science.

The accredited programs in medical assistance provide training in administration, laboratory techniques and clinical procedures. Course work includes study of anatomy and physiology, medical terminology, medical law and ethics, insurance and bookkeeping.

The following is a list of the 87 students who have successfully completed the recent Medical Assistants' examination for certification by the State of Illinois.

Jane L. Allen, Belleville—CMA  
Marija Allen, East St. Louis—CMA—C  
Margaret Emily Armstrong, Macomb—CMA—C  
Cynthia Elaine Battle, Round Lake Heights—CMA  
Janet T. Beckley, Bourbonnais—CMA  
Judith Sue Bell, R. T., Carthage—CMA—C  
Diane Louise Boudreau, Naperville—CMA—C  
Eunice Catherine Budzinski, Riverside—CMA—A  
Erlinda S. Buenfil, Chicago—CMA—C  
Lori Lynn Burhop, Cary—CMA—C  
Patricia Concagh, Evergreen Park—CMA  
Constance Condon, Maywood—CMA  
Cindy L. Crawford, Freeport—CMA  
Elaine Ruby Danielson, Moline—CMA—C  
Mary J. Davis, Evergreen Park—CMA  
Susan I. Davis, Chicago—C  
Susan Denis, Belleville—CMA  
Debra Ann Dorken, Chicago—CMA—C  
Teresa L. Duffield, Baileyville—CMA  
Debra Jean Duke, Arlington Heights—CMA  
Cheryl Lois Eichmann, Oak Lawn—CMA—A  
Patricia A. Evans, Trenton—CMA  
Mary Susan Fidale, Mt. Prospect—CMA  
Jerri Lynn Fink, Crete—CMA—C  
Katherine Sandra Fisch, RN, Carthage—CMA—C  
Susan Bernice Gapinski, Lake Villa—CMA  
Teresa E. Gettman, Mendon—CMA—C  
Judith Anne Gibson, Pekin—CMA  
Pamela Jean Halterman, Belleville—CMA—C  
Susan J. Healy, Evergreen Park—CMA  
Donna J. Herrick, Lansing—CMA—A  
Linda C. Herrick, Lansing—CMA—C  
Margaret Rose Hoff, Burbank—CMA  
Gloria Dawson Hoover, Evanston—CMA—A  
Linda Rhosan Horwedel, Vermont—CMA  
Deborah Lynn Jackson, Aurora—CMA  
Anke Jessen, Woodstock—CMA  
Claretta Jordan, Glen Ellyn—CMA  
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Elaine E. Maier, Joliet—CMA  
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Kathy Jo Mattingly, Normal—CMA  
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Cissy A. Moran, Joliet—CMA  
Karen L. Morris, Harvard—CMA—C  
Loni Rae Morris, Calumet City—CMA  
Patricia A. Neet, Effingham—CMA—Ped  
Carol Kay Neighbors, Mt. Vernon—CMA  
Linda Lee Novak, Chicago—CMA  
Ruth C. Ohrem, Chicago—CMA—A  
Dawn Marie Olsen, Lansing—CMA  
Patricia Parks, Chicago—CMA—A  
Florence R. Peery, Chicago—CMA  
Debra A. Petersen, Chicago—CMA  
Ruby Pharris, Moline—CMA—C  
Virginia Lee Raap, Rockford—CMA—C  
Kathleen N. Reardon, Roselle—CMA—A  
Scarlett Roberts, White Hall—CMA—C  
Melody Ann Schafer, Warsaw—CMA—A  
Karen Lynne Short, Freeport—A  
Donna Jean Soprych, Chicago—CMA  
Cheryl J. Steiber, Carthage—A  
Linda D. Stogner, Waterloo—CMA  
Beth Lynn Stohliquist, St. Charles—CMA  
Sherrie F. Sykes, Downers Grove—CMA  
Susan Ann Treece, Naperville—CMA  
Mary H. Ullrich, New Lenox—CMA  
Nijole P. Uzubalis, Chicago—CMA—A  
Avis E. Vedder, Murrayville—CMA—C  
Julia Agnes Veith, Mount Sterling—CMA—C  
Michele Lucia Vicari, Chicago—CMA—C  
Pamela Ann Vlosak, Evergreen Park—CMA  
Sharon Lea Wakeman, Thornton—CMA—A  
Mary Jo Weis, Highland—CMA—C  
Cheryl A. Wright, Pekin—CMA—C





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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.*

**ARCOLA:** F.P. or G.P. needed to join only physician in true rural community (2,300 population). Must be willing to do O.B. Ultimate plans for new 3-man clinic. Close to beautiful county hospital less than 10 years old. Robert N. Arrol, M.D., 126 S. Locust, Arcola, Illinois, 61910. (217) 268-4444 or (217) 268-4404. (3)

**ARLINGTON HEIGHTS:** Board Certified Family Practitioner wishes associate who is Board certified or eligible in Family Practice. Modern office located across from Community hospital. Liberal salary and time off for study and vacations. Partnership after one year. Send resume to: Dr. Alan M. Hollett, 605 W. Central Rd., Arlington Heights 60005. (12)

**BLOOMINGTON:** Two active Internists seek Family Practitioners and Pediatricians to join evolving private group of primary-care practitioners. Group to consist of six physicians leasing office space in Hospital-owned building. Organized within a Community Health Center setting. Contact: Michael Daniloff, Vice-President, Professional Services, Mennonite Hospital, 807 North Main Street, Bloomington, 61701 (309) 828-5241. (3)

**CAIRO:** F.P. and internist sought. Rural service area—20,000 population. Excellent salary. Fringe benefits including malpractice. Office and staff provided. Med staff privileges in 62 bed acute hospital with peds, OB/GYN, and surgery specialties. Excellent recreation—fishing, hunting, tennis, golf. Private and public schools. Jr., 4 yr. and Med schools nearby. Contact: N. Pettry, 2020 Cedar, Cairo. 618-734-2400. (1)

**CARBONDALE:** Family physician: Innovative Neighborhood Health Center in Southern Illinois seeks Family Practice Physician to provide patient care and supervise other professionals, para-professionals in clinic setting. Salary negotiable. Position available October 1976. Write: Robert Stalls, Director of Human Resources, City of Carbondale, 602 E. College Street, Carbondale, Illinois 62901, (618) 549-5302. (2)

**CHAMPAIGN:** General Internist, Pulmonary Medicine, Allergist, Oncologist/Hematologist, Rheumatologist, Family Practitioner, Dermatologist, Neurologist, Urologist and ENT opportunities in 31-man multi-specialty, youth-oriented group. Guaranteed salary leading to early Associateship with future income based on individual productivity. Medium sized, Big-10 University community. Contact Mr. Arthur H. Perkins, Administrator, Christie Clinic, 104 West Clark Street, Champaign, 61820 (217) 351-1200. (3)

**CHICAGO:** Medical center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice. Contact: F. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625, 312-478-6000 (2)

**CHICAGO:** Internist: board certified, wanted for association with hospital based medical/surgical group. Very large, active practice. North side Chicago. Unusual opportunity. Write Mr. C. M. Rappaport, Director of Personnel, 5700 North Ashland Avenue, 60660. (12)

**CHICAGO:** Physician needed for well established, ultra modern medical center. Full laboratory and X-ray. Congenial working conditions and excellent co-workers. Good hospital associations. No evenings or weekends. Clinic located south side, near lake. Contact, Mr. Lawrence, Booker Family Health Care Center, 747 E. 47th, Chicago, 60653, (312) 624-4800. (1)

**CHICAGO:** Staff Pathologist with a desire to develop new clinical laboratory procedures and work with an innovative specialized Medical Staff, needed to join our progressive university-affiliated Chicago hospital. Must be certified/eligible in clinical and anatomic pathology and interested in teaching. Excellent salary and benefit program. Write or call: Nancy Siegel, Staffing Specialist, Louis A. Weiss Memorial Hospital, 4646 North Marine Drive, Chicago, 60640, (312) 769-2162. (3)

**CLINTON:** Population 8500. Opening for solo general practice. Four physicians in General Practice at present. Twenty-five miles from Decatur and Bloomington. Office Available. Recreational facilities excellent. Clinton Nuclear Power Plant under construction 6 mi. east of City. Contact: M. J. Hein, 422 West White, Clinton 61727, AC 217-935-3171. (2)

**COLLINSVILLE-EDWARDSVILLE:** Progressive towns, 15 miles from Downtown St. Louis. Ample recreational facilities, S.I.U. Campus nearby. New Community Hospital will open this summer. Need a qualified Ophthalmologist. No initial investment needed. Excellent opportunity for the future. Contact Mrs. Hall, 657 E. Broadway, East St. Louis 62205, (618-345-0417). (12)

**DANVILLE:** Need Primary Care Physicians. Also Neurologist(s) and/or Neurosurgeon(s). Population 43,000. Service Area 180,000. Excellent schools, near university. Contact R. V. Livengood, Lakeview Medical Center, Danville, 61832 (217) 443-5201. (3).



**FAIRFIELD:** Group of 4 physicians, GP, gen. surgeon, Gyn.-OB, and pediatrician, looking for another OB-Gyn. man. Population 6500, excellent hospital facilities, generous salary and all the benefits of corporation assured. Illinois license. Contact S. W. Konarski, M.D., 101 E. Center St., Fairfield, 62837, 618-842-2187. (12)

**FORT MADISON, IOWA:** Opening for 2 FP/GP, OB, Int. in growing industrial city of 16,000 serving 70,000 on Miss. River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, Xlnt, living area, 125 bed accredited hospital. Contact Donald A. Buckert, Sacred Heart Hospital, Fort Madison, Ia. 52627, 319-372-6530. (12)

**HARVEY:** General Practitioner or Family Practitioner opening available in our practice. Practice in the Chicago area and in the south suburb. Good pay and benefits. Interested parties please contact 333-1411 or P.O. Box 677, Harvey, 60426. (3).

**ILLINOIS:** Variety of settings in agencies providing diagnostic, treatment, consultative and advisory services or administrative direction to medical programs. Completion of approved Medical school and 1 year internship/residency in approved hospital required. Must possess or acquire appropriate valid Illinois license before employment. Temporary certification not acceptable. Salary commensurate with skills and experience—Good benefits. Equal Opportunity Employer—Male or Female. Send resume to: Robert P. Gosnell, Manager, Counseling Services and Administrative Recruitment, Illinois Department of Personnel, 521 State Office Building, Springfield, Illinois 62706. (1)

**JUSTICE:** One or two good Family Practitioners needed: lovely new Medical Center (Southwest), on-site Surgery Center, X-Ray, Laboratory, Emergency Room and Pharmacy; complete staff 15 doctors for various specialties who are on staff at nearby 500 bed hospital. Opportunity for future partnership. Contact Dr. E. I. Breslar, Forest Hill Medical Center, 9050 W. 81st, Justice 60458. 312-594-3500. (2)

**McHENRY:** We have openings available for Board Certified or eligible OB-GYN, Pathologist and Orthopaedic physicians on the staff of our 23 physician multispecialty group. Incentive pay from day one with minimum guaranteed draw, malpractice paid, partnership after 1-2 years, excellent fringe benefits. We are 55 miles northwest of Chicago in the Chain-o-Lakes resort area. The Medical Group is physically adjacent to a 147 bed general community hospital and State Trauma Center. Jim Dickson, Personnel Director, McHenry Medical Group, McHenry 60050. (815 385-1050 ext. 332. (2)

**OLNEY:** ENT, Internal Medicine, Dermatology, Ophthalmology needed. 26 MD multispecialty partnership, 15,000+ referral population, new bldg., 1st yr. earnings guaranteed, 200 bed modern hospital, 4 wks. vacation, 2 wks. meeting per yr. Contact: David L. Potter, Adm., Weber Medical Clinic, 1200 N. East St., Olney 62450 (618) 395-4311. (2)

**OLNEY:** Radiologist to head a new department with another radiologist in a 150 bed hospital with 50 bed addition under construction. Recreational facilities nearby. Community of 10,000. Method of compensation negotiable. Contact Harold Kaseff, Administrator, Richland Memorial Hospital, Olney, 62450. 618-395-2131. (12)

**ORLAND PARK:** Orland Park and far S.W. Chicago office, need general practice physicians, complete facilities both offices. New office bldg. completed Dec. 1, 1976. Contact: C. E. Cornelison, Adm., 10444 S. Kedzie, Chicago 60655, (312) 239-3000. (1)

**PINCKNEYVILLE:** Population 3500—Serves an area of 20,000. Medical group partnership of four physicians seeking fifth member. Complete office facilities—2 Blocks from fully accredited hospital. Salary one year—then partnership. Good recreational facilities—near St. Louis. Contact: Clarence E. Cawvey, M.D., 206 North Main Street, Pinckneyville 62274 Phone: 618-357-2131. (2)

**ROCHELLE:** Population 10,000—Two primary care physicians needed. Hospital serves an area of approximately 20,000. Acute general 68-bed hospital with full services, including physical and respiratory therapies. Office space available adjacent to hospital. Located 25 miles from Rockford and a medical college, 17 miles from major university, and an hour-and-a-half from Chicago. Excellent schools, parks and civic organizations. Contact Administrator, Rochelle Community Hospital, 900 North 2nd Street, Rochelle 61068 (815) 562-2181. (2)

**ROCKFORD:** Opening for Board eligible Internist in multi-specialty group of internists. Brand new building; two minutes from large, modern hospital. Near Rockford School of Medicine—part time teach opportunities if desired. Guaranteed income with full partnership after one year. 90 miles NW of Chicago on I-90. CONTACT: T. R. Glatter, M.D., 5670 E. State St., Rockford 61108. 815-398-4040 or 815-877-0096. (2)

**ROCK ISLAND:** Family practitioner, excellent guarantee and office arrangements. Send C.V. to Thomas J. Lavery, 2701-17th St., Rock Island, Illinois 61201 or call (309) 793-1000 (collect) for additional information. (1)

**SPRINGFIELD:** Emergency physician needed to supplement existing department in 650 bed community hospital with medical school affiliation. New emergency department facilities, 50,000 visits per year, excellent salary and fringe benefits, 40-44 hour week. Teaching position available if desired. Involvement with ongoing MERCI communications net and paramedic training program. Excellent opportunity to work, teach, and live in progressive midwest community with a metropolitan area of approximately 150,000. Contact E. W. Donelan, M.D., Chairman Emergency Services, St. John's Hospital, 800 East Carpenter, Springfield, 62702, 217-544-6464. (3).

**WAYNE CITY:** Thriving community located in Wayne County in southern-most Illinois. Office facilities furnished for young Family or General Practitioner. No physicians in this community. Contact: Grant Smith, President, First National Bank, Wayne City 62895; 618/895-2118. (2)

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT** and Emergency Room. Become part of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801. Phone (217) 337-3239.

**OB-GYN, PEDIATRICS SPECIALISTS** needed by 16-man multispecialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., La Crosse Clinic, 212 South 11th Street, La Crosse, Wisconsin 54601.

**EXCELLENT OPPORTUNITY AND ENVIRONMENT**—Physician needed to practice general medicine in large outpatient clinic and 3B bed fully accredited hospital. Must possess empathy toward college age population. Salary negotiable, excellent fringe benefits. Contact L. W. Combs, M.D., Purdue Student Hospital, West Lafayette, IN 47907, 317-749-2441. Equal access/equal opportunity employer.

**UROLOGY:** Board eligible seeking position for solo, group, or assn. leading to partnership. Send reply to Illinois Medical Journal, Box 868, 55 E. Monroe, Suite 3510, Chicago 60603. Or phone (312) 449-2377.

**RADIOLOGY:** Gen. Radiology residence completing Dec. 76. Seeking position for solo, group, or assn. leading to partnership. Send reply to Illinois Medical Journal, Box 868, 55 E. Monroe, Suite 3510, Chicago 60603. Or phone (312) 449-2377.

**EMERGENCY MEDICINE:** Career opportunities available in E.D. medicine. Also short-term and locum tenens. Urban and rural Illinois, Missouri, Ohio and Colorado locations. Flexible work schedules, competitive remuneration. Paid malpractice, vacation, educational leave, interview expenses. Call Doctors Cooper or Spurgeon toll-free 1-800-325-3982 or send C.V. to Box 11241, St. Louis, Missouri 63105.

**FAMILY PRACTITIONER WISHES ASSOCIATE** who is Board certified or Board eligible in family practice to join family practice. Located in Waterloo, Iowa, a northeast Iowa community of 75,000. All records dictated on the Problem Oriented Medical Records System. Ronald R. Roth, M.D., 611 Black's Bldg., Waterloo, Iowa 50703.

**NEONATOLOGIST** to join 9 member Pediatrics Division of a 90 doctor multi-specialty clinic with adjacent hospital; located in Big 10 University community of 100,000; large referral practice, as well as primary care; new medical school offers opportunity for teaching; hospital has just under 1000 deliveries per year with 13,000 per year in area without designated center; OB/Pediatrics Departments are requesting state designation as perinatal center with completion in early 1977 of excellent new hospital, L & D, NICU facilities. Contact Medical Director, Carle Clinic, Urbana 61801.

**PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT** and Emergency Room. Become part of an expanding, dynamic multispecialty clinic in mid-west university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana 61801, (217) 337-3239.

**BOLINGBROOK**—population 30,000, drawing area 70,000. Growing at a rate of 4,000 people a year. Four M.D.'s established in the community. Urgent need for additional M.D.'s in all fields, particularly, OB and Peds. Associate or solo available. Send resume to: Manager, Bolingbrook Professional Building, 519 E. Briarcliff Road, Bolingbrook, Illinois 60439; (312) 739-5121.

**PEDIATRIC NEUROLOGIST** to join 9 member Pediatrics Division of a 90 doctor multispecialty clinic with adjacent hospital; located in Big 10 University community of 100,000; large referral practice, as well as primary care. New medical school offers opportunity for teaching; clinic has 3 member Neurology Department and active neurosurgical program, an EMI scanner and potential for limitless growth in neurosciences. Contact Medical Director, Carle Clinic, Urbana 61801.

**OB-GYN, UROLOGY, AND ORTHOPEDIC** specialties to join an established successful practice with 15-man multi-specialty group. Excellent group benefits; retirement plan; modern clinic facilities; progressive community with excellent educational system including two colleges; area population 75,000; great recreational facilities; must be board eligible or certified; Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

**TWO FAMILY PHYSICIANS** with large hospital practice wish third associate who is Board Eligible, to join busy family practice. Located in Waterloo, Iowa, a northeast Iowa community of 75,000. All records dictated on the Problem Oriented Medical Records System. Ronald R. Roth, M.D. & Ronald D. Flory, M.D., 611 Black's Bldg., Waterloo, Iowa 50703.

**FAMILY PRACTICE POSITION** for one or two physicians. Satellite expansion to nearby smaller town in Southern Wisconsin provides excellent opportunity of enjoyable living. Administrative, retirement, technical and time-off coverage of a large group. No investment. Weekend coverage. Contact Frank C. Stiles, M.D., The Monroe Clinic, Monroe, Wis. 53566 or call (608) 328-7000.

**FAMILY PHYSICIAN**—unmatched opportunity to head up new primary care center in attractive Chicago suburb. No investment requirement. Guaranteed income and benefits. Early partnership. Limited call. Excellent specialty back up. No management headaches, unless desired. Will tailor practice responsibilities to individual needs. Reply Box #869 c/o IMJ, Suite 3510, 55 E. Monroe, Chicago, 60603.

**Physicians, Southeast Missouri.** Needed Immediately. Excellent opportunity, salary open for discussion. Call COLLECT 314-785-7701 ext. 61.

**FAMILY PRACTICE, INTERNAL MEDICINE, OBSTETRICS-GYNECOLOGY** The above physicians wanted to join an expanding, multispecialty group in Southwestern Michigan. Clinic is located next to an B9 bed general hospital, with excellent staff and equipment, provide high quality medical care. All members of the group are board certified or eligible. Excellent fringe benefits and starting salary. Please write or call: Gary Piippo, Administrator Allegan Medical Clinic, P.C., 551 Linn St., Allegan, Michigan 49010. Phone: Area Code 616-673-8402.

**ILLINOIS—EMERGENCY PHYSICIANS WANTED. EARN UP TO \$78,000** per annum in low volume or busy ER's. Work two days, off five, earn \$50-\$60,000. Work only 26 weeks, earn \$50-60,000. For further information write BOX NUMBER 871, IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**ILL. G. P.** Fully equipped Clinic. Eighty miles from St. Louis, on major interstate. Access to two hospitals, only doctor in town, re-locating. Gross over \$125,000. No investment. Rent or lease. Very reasonable. Evenings (618) 829-3851.

**M.D.'s . . .** There is an alternative in your medical career. The challenge of pharmaceutical research, and its significant rewards, can offer a whole new perspective to your career; and you can enjoy a new-found personal freedom that does not exist in the disruptive and demanding realm of private practice. As a Clinical Research Physician at Parke-Davis, you will be working out of our modern Research Center—located in Ann Arbor, Michigan. Overall responsibilities would be to plan, develop, and monitor clinical research studies of investigational new drugs to determine safety and efficacy. Candidates should be Board Certified (or eligible), preferably with specialized training in internal medicine or pediatrics and previous private practice experience. You will earn an attractive salary with broad-based benefits, and the professional satisfaction that accompanies successful development of new, safe, effective drugs. Consider joining us in Clinical Research—to find out more, simply write: Personnel Supervisor, Parke, Davis & Company, 2800 Plymouth Road, Ann Arbor, Michigan 48106. An Equal Opportunity Employer M/F.

**OBSTETRICIAN** to associate with OB-Gyn Department of established multispecialty group in St. Paul-Minneapolis and suburban areas. Excellent salary, generous fringe benefits. Tremendous growth potential in one of America's leading metropolitan areas. Curriculum vitae and references invited. Box 80100, St. Paul, Minnesota 55108.

**PHYSICIANS,** Family Practice, preferable with some psychiatric experience for a community oriented mental health center located in semi-urban surroundings with access to metropolitan Chicago. JCAH accredited, Illinois licensure required. Salary range competitive. Excellent fringe benefits. Send vitae to A. T. Waskowicz M.D. Tinley Park Mental Health Center, 7400 West 183rd Street, Tinley Park, Illinois 60477.

**PSYCHIATRIST:** STARTING SALARY \$35,000-\$45,000. Prefer two years experience in Community Psychiatry. To carry treatment and supervisory responsibilities in a progressive and growing community mental health center. Medical staff includes two full-time psychiatrists and a complement of psychiatric consultants. A reasonable work pace and pleasant facilities. Enjoy with us the benefits of living and working in a scenic, rural community on the Ohio River, with the added advantage of being only 30 minutes from downtown Cincinnati, Ohio. Contact James F. Jones, Executive Director, Community Mental Health-Mental Retardation Center, Inc., 285 Bielby Road, Lawrenceburg, IN 47025. Equal Opportunity Employer.

## FOR SALE, LEASE OR RENT

**BUY OR RENT AN 800 SQ. FT. SUITE,** luxuriously finished and absolutely independent in a recently completed 13 Suite Professional Center in Barrington, Ill. A desirable place to practice and to live. Ample paved parking and just a few blocks from the recently approved 166 Bed Good Shepherd Hospital. Inquire now while the selection is good. Excellent terms. Write to Box 866, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago Ill. 60603.



**Blue Cross®  
Blue Shield®**



# REPORT

## FOR *Illinois Physicians*

### New Type Blue Cross-Blue Shield ID Cards To Be Issued

The Illinois Blue Cross-Blue Shield Plan will begin issuing a standard type, computer-printed plastic membership Identification Card after the first of the year. The standard membership card was adopted for use by all Blue Cross-Blue Shield Plans beginning in 1977.

In addition to local member accounts (a sample of our local card is reproduced below) the new single format will accommodate and clearly identify subscribers enrolled in the Blue Shield Reciprocity program. This card has distinct lettering and the subscriber's Home Plan number is enclosed in a double-pointed red arrow in the center.

Distribution of cards from the Plan's Chicago office *will be limited* in the beginning to newly-enrolled groups and to new subscribers in direct payment and existing group accounts. The process of replacing cards currently in use will be done over a period of two years. *All current membership cards, therefore, should be accepted until the replacement process is completed.*

Changes in the card are expected to improve the delivery of membership services: the plastic card is more durable; the number of different cards issued will be reduced with a standard card; subscriber identification data is more complete; and an important change involves indicating the member's basic coverage in digit codes on the face of the card for the first time. Coding is shown on the sample card and explained in further detail below.

#### Design & Wording

The wording "Blue Cross-Blue Shield, Chicago, Illinois" appears across the top on local account and Reciprocity cards. The city and state are

omitted on the national account card. Our corporate emblems and the outline map of the United States are unchanged from previous cards. On the Reciprocity card, the outline of the box for the Subscriber Identification Number and double-pointed arrow for the subscriber's Home Plan number are in red. On National Account Cards issued by the Chicago office, the wording "Central Certification" appears in the map of the U.S.

#### Subscriber Identification & Coverage Codes Explained

Computer-printed subscriber Identification and Coverage data on the new cards will be similar to that shown on the sample card, varying with the member's type of enrollment and coverage:

- (Line 1) Name of the Subscriber
- (Line 2) Complete Identification Number in box  
(Group-Subscriber Number)
- (Line 3) Group Number repeated
- (Line 4) Coverage Codes: (e.g.) F BC/BS 1/20/77
- One digit code (S or F) indicates single or family coverage.
- Five digit code indicates type of basic coverage:
  - BC/BS —Basic Blue Cross and Blue Shield only
  - C/S/M —Basic BC, BS and Major Medical only
  - MM —MM only
  - BC —BC only
  - BS —BS only
  - BC/MM —Basic BC and MM only
  - BS/MM —Basic BS and MM only
  - CMM —Comprehensive Major Medical
 (Blanks indicate absence of basic coverage.)
- Eight digit code indicates drug coverage.  
RX-\$.X.XX—When drug coverage is present (X.XX indicates the amount of coinsurance payment in dollars).
- Five digit code indicates dental coverage.  
DENTS—Dental coverage for subscriber only.  
DENTF—Dental coverage for subscriber and the covered dependents.

Most current contract change date appears on Line 4: (i.e.) 1/20/77.

In lines below the coverage codes the card will also accommodate the subscriber's Social Security Number, and for groups, the section number and location number of the employee; plus the name of the company on the last line, if desired.

On the reverse side of the card are brief instructions to hospitals and physicians on subscriber identification and benefit entitlements; and to the physician is the request that in completion of the Blue Shield Physician Service Report form, to please include the complete Identification Number of the member appearing in the box before sending it to Health Care Service Corporation, 233 North Michigan Avenue, Chicago, Illinois 60601 for payment.

		<b>Blue Cross Blue Shield</b> CHICAGO, ILLINOIS		
Doe, John				
Identification No.		80026 - 12345		
Group No. 80026		BS Plan Code 621	BC Plan Code 121	
F BC/BS		1/20/77		

#### Local Blue Cross-Blue Shield ID Card

(This report is a service to the physicians of Illinois)

### Payment Of Reasonable Charges For Components of a Series

The Bureau of Health Insurance of the Social Security Administration requires Part B Medicare carriers (Health Care Service Corporation in Cook County) to limit the reasonable charge for diagnostic blood tests and X-rays, which are generally components of a series.

If, for example, specific blood tests when billed individually accumulate a higher reasonable charge than that billed to the carrier for a complete series (e.g. an SMA-12 or a CBC) the claim will be reviewed under our prepayment utilization review system. Similarly, if individual X-ray examinations are of the type that are generally components of a series (e.g. upper and lower G.I.) and the billing accumulates to a charge higher than the more economical charge for the entire series, the claim will be reviewed.

In the review, a determination is made as to the "reasonableness" of the tests being billed on an individual basis rather than as a complete series. If the decision is that the tests could have been performed as part of a series, the Part B carrier will reduce the reasonable charge to the maximum allowable for the series.

### Compliance with New Illinois Law

In complying with Illinois law enacted October 1, 1976 physicians are required to show on their bills to patients or to the Part B Medicare carrier when filing a Medicare claim, the name of the laboratory that performed the individual test or series of tests, names of the tests and the amount or amounts charged for each test or test series by the laboratory and the drawing fee or processing charge for each test or test series.

If the SSA 1490 claim form is used to file for an outside laboratory service, the laboratory should be identified in Item 13 and the letter "IL" placed in Item 7B.

When a claim for services includes tests performed by a laboratory not certified in its specialty by Medicare, payment is denied. However, denial of payment for a test does not affect payment for the office visit, which usually includes the physician's charge for evaluating and interpreting the laboratory report.

### Patient Signature Requirements On Medicare Claims

Medicare claims cannot be processed if signature requirements are not properly met. All assigned claims must have the patient's signature unless:

- (1) The patient is on Public Aid; then the Public Aid number must be entered under Item 5 on the Medicare form.
- (2) The patient is deceased; simply state "patient deceased."
- (3) The patient is unable to sign; in which case Medicare requires the signature of a witness, such as a relative or close friend.

All non-assigned claims must have the patient's signature if the patient has not paid his bill in full. If no balance remains on the patient's bill, the signature is not required, although it is preferable for legal purposes.

Medicare cannot accept the statement "*signature on file*" on claims. Although these requirements may appear rather severe, they are intended for the physician's protection as well as the patient's.

### SSA Changes in Lab Certification

Notice was received from the Bureau of Health Insurance Office, Social Security Administration, of the following changes in participation or certification status of laboratories in the Medicare program:

Kendon Medical Laboratory Inc., 8625 S. Cicero Avenue, Chicago 60652 (Provider Number 14-8052) is no longer approved by the Illinois Department of Public Health to perform Procedure 130-Parasitology effective October 1, 1976. The laboratory is approved to perform procedures in Bacteriology, Serology, Chemistry, Blood Grouping and Rh Typing, EKG Services and Hematology.

Norsom Medical Reference Laboratory, 710 Higgins Road, Park Ridge 60063 (Provider Number 14-8253) is no longer approved by the Illinois Department of Public Health to perform Procedure 120-Myology and 150-Microbiology. The laboratory is approved to perform procedures in Serology, Chemistry, Hematology, Diagnostic Cytology and EKG Services, Bacteriology and Parasitology.

Northwest Medical Arts Laboratory, 1100 W. Central Rd., Arlington Heights 60005 (Provider Number 14-8291) is no longer performing Procedure 130-Parasitology upon the advice of the Illinois Department of Public Health, effective November 1, 1976. The laboratory is approved for procedures in Serology, Hematology, Routine Chemistry and Clinical Microscopy, Blood Grouping and Rh Typing, Rh Titers and Bacteriology.

Professional Arts Medical Laboratory, 601 W. Central Road, Mt. Prospect 60056 (Provider Number 14-8187) is no longer approved by the Illinois Department of Public Health to perform Procedure 330-Chemistry-Other effective October 1, 1976. The laboratory is approved to perform Serology, Hematology, Routine Chemistry and Clinical Microscopy.



# But she may not have the stomach for APC.

Or the kidneys, for that matter.

Even bleeding time and platelet aggregation can be maximally prolonged by a single aspirin tablet.\*

We took that into account in revising the formula of Phenaphen® with Codeine, and combined codeine (in any of three different strengths) with acetaminophen to complement the codeine with little risk of APC complications. While there's no anti-inflammatory activity, there's no aspirin to aggravate G.I. problems or adversely affect bleeding time. Similarly, there's no potential renal risk from phenacetin, and no caffeine to stimulate patients unnecessarily.

There is the convenience of telephone Rx under Federal law...and the complementary analgesic efficacy of acetaminophen.

Phenaphen® with Codeine. Not just for patients who might have a "compound" problem, but for almost every patient who needs codeine. It's a lot simpler than APC.

## BRIEF SUMMARY

**Contraindications:** Hypersensitivity to acetaminophen or codeine.

**Warnings:** *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

*Usage in ambulatory patients.* Caution patients that acetaminophen and codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

*Interaction with other CNS depressants.* Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

*Usage in Pregnancy.* Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

**Precautions:** *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

*Acute abdominal condition.* Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

*Special risk patients.* Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

**Adverse Reactions:** Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

**Drug Interactions:** CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.



## Phenaphen® with Codeine No.3

Codeine Phosphate, USP-30 mg  
(Warning: May be habit forming)  
Acetaminophen, USP - 325 mg

### to complement codeine with little risk of APC complications

\*Mielke, C.H., et al.: JAMA  
235:613 (Feb. 9) 1976.

## A-H-ROBINS

A.H. Robins Company  
Richmond, Va. 23220

# Clinics for Crippled Children

## Listed for January

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be eight special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

January 4	Quincy, Blessing Hospital
January 5	Cairo, Public Health Department
January 5	Hinsdale, Hinsdale Sanitarium
January 6	Sterling, Community General Hospital
January 6	Effingham, St. Anthony Memorial Hospital
January 6	Lake County Cardiac, Victory Memorial Hospital
January 7	Division Cardiac, University of Illinois Hospital, Center for Handicapped Children
January 10	Peoria Cardiac, St. Francis Children's Hospital
January 12	Mt. Vernon, Good Samaritan Hospital
January 12	Champaign-Urbana, McKinley Hospital
January 12	Chicago Heights General, St. James Hospital
January 12	Joliet, St. Joseph's Hospital
January 13	Springfield, St. John's Hospital
January 13	Macomb, McDonough District Hospital
January 14	Chicago Heights Cardiac, St. James Hospital
January 16	Maywood, Loyola Medical Center
January 18	Belleville, St. Elizabeth's Hospital
January 18	Rock Island, Moline Public Hospital
January 18	Decatur, Decatur Memorial Hospital
January 19	Springfield Pediatric-Neurology, St. John's Hospital
January 19	Centralia, St. Mary's Hospital
January 19	Evergreen Park, Little Company of Mary Hospital
January 20	Rockford, Rockford Memorial Hospital
January 20	Elmhurst Cardiac, Memorial Hospital of DuPage County
January 24	Peoria Cardiac, St. Francis Children's Hospital
January 25	Park Ridge Cardiac, Lutheran General Hospital
January 26	Elgin, Sherman Hospital
January 26	Chicago Heights General, St. James Hospital
January 28	Chicago Heights Cardiac, St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant, activities of other agencies.

# OBITUARIES

\***Amberson, Henry R.**, Chicago, died October 3rd at the age of 79. Dr. Amberson was a 1924 graduate of the University of Illinois.

\***Fredrick, V. L.**, Freeport, died September 3rd at the age of 44. Dr. Fredrick was a 1957 graduate of the St. Louis University School of Medicine.

\***Furman, Leon M.**, Chicago, died October 21st at the age of 68. Dr. Furman was a 1935 graduate of the University of Chicago Medical School.

\***Harding, Harry B.**, Glenview, died September 12th at the age of 68. Dr. Harding was a 1946 graduate of Northwestern University.

**Knauer, Cornelia S.**, Chicago, died April 8th at the age of 88. Dr. Knauer was a 1920 graduate of the University of Illinois College of Medicine.

\***Levine, Herbert J.**, Centralia, died October 28th at the age of 69. Dr. Levine was a 1935 graduate of the Chicago Medical College.

\***Melamed, Myron**, Highland Park, died October 4th at the age of 54. Dr. Melamed was a 1945 graduate of the University of Illinois.

\***Miller, Edward E.**, Cairo, died October 17th at the age of 75. Dr. Miller was a 1927 graduate of the University of Illinois.

\***Ramonas, Julius A.**, Orland Park, died October 21st at the age of 51. Dr. Ramonas was a 1952 graduate of the University of Munchen.

\***Squire, Fay H.**, Wheaton, died October 9th at the age of 75. Dr. Squire was a 1925 graduate of the State University of Iowa.

\***Stein, Irving F.**, Glenco, died October 13th at the age of 89. Dr. Stein was a 1912 graduate of Rush Medical College.

\*Indicates ISMS member

\*\*Indicates ISMS member and member of the Fifty Year Club

**CORRECTION:** The October issue of IMJ included an error in the ISMS Policy Manual (p. 319). ISMS does not endorse the legalization of the possession or use of marijuana. Since medical and psychiatric knowledge concerning the short term and long term effect of cannabis is very limited, medical research should be supported by public and private sources of the State of Illinois.



# Editorials



## Problems Problems Problems

The medical profession is being confronted with potentially revolutionary problems. Third party quarrels are not new, but they now extend to local and federal governments, giant insurance companies, consumerism and malpractice suits. As we near the end of another year these and other health care problems remain unsolved, and some newly selected administrators may add to our woes.

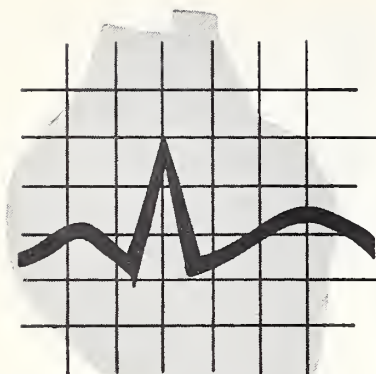
The widely publicized "Medicaid abuse" is nothing more than an extension of governmental harassment of the medical profession. The ruling that anyone who bills the government for \$100,000 or more per year must be reported to the press is pure propaganda. It was recently reported that the average sum spent on a congressman exceeded \$400,000 annually. Physicians and pharmacists have been singled out to the exclusion of others who receive public money for professional services.

By innuendo alone, those who treat large number of Medical patients are alleged to be guilty of fraud or illegality. In one instance, fees were sent under the name of one physician, representing the services of his clinic of six full time and six part time doctors. The \$100,000 represented bills rendered and not money received. It was gross, not net. Although the government admitted that there was not evidence of wrongdoing, this arbitrary ruling would require that they be reported to the press.

Meanwhile, the individual physician is beginning to incorporate and to bill patients through a clinic or corporation. Physicians and hospitals are grouping in order to provide good medical care at more reasonable prices. Hospitals, following in the footsteps of industry, are beginning to merge. By consolidation they can avoid duplication of expensive equipment and obtain the benefits of centralized purchasing and billing. The next step, I fear, is to bring the physician under the hospital umbrella. We already have many hospital-based physicians in group practice. They prefer the security that no longer exists among solo practitioners.

Although tempted to recall the days when doctors ran their own affairs and their judgment was not influenced by governmental intervention, we cannot look back. The poor and needy are not as yet receiving the care they should, but physicians are not entirely to blame. The federal government is so involved in red tape they cannot improve upon the private sector. Our country cannot afford and does not need federally administered comprehensive national health insurance. But the movements of the present will determine the health care of the future.

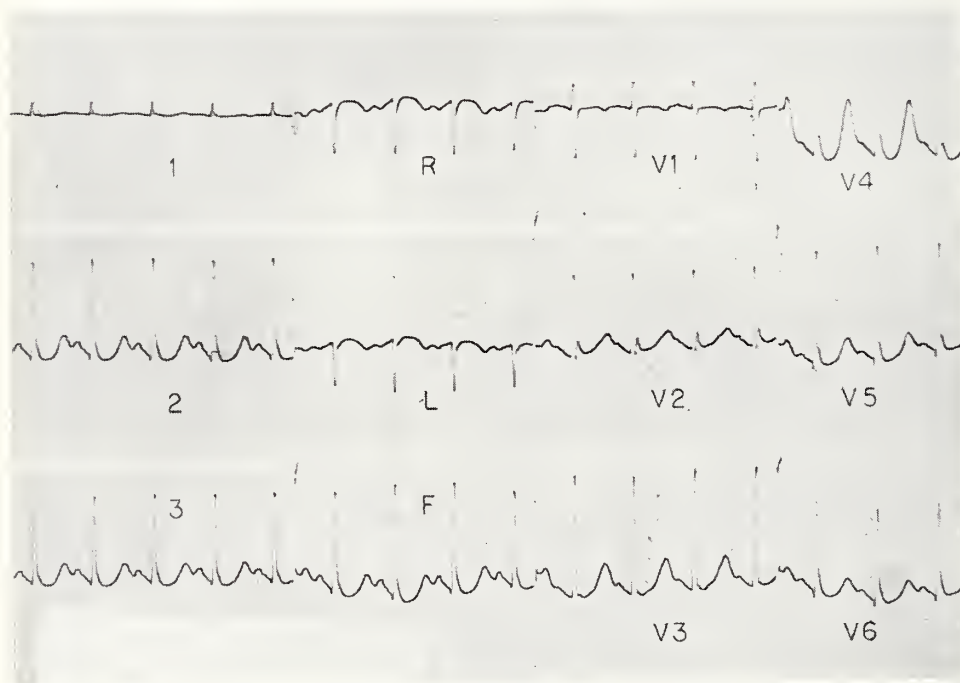
T. R. Van Dellen, M.D., *Editor*



## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RINGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

A 53-year-old woman was admitted to the hospital following a syncopal episode. On examination the patient was comatose without lateralizing signs. Cardiovascular examination was within normal limits. An electrocardiogram was taken.



### Questions:

#### 1. The tracing shows:

- A. Prolonged QT interval.
- B. Tall T waves.
- C. Absence of Q waves.
- D. Absence of hyperactive infarction changes.
- E. All of the above.

#### 2. The electrocardiographic changes are suggestive of:

- A. Acute anterior wall myocardial infarction.
- B. Complete A-V heart block.
- C. Sino-atrial block.
- D. True posterior myocardial infarction.
- E. Cerebrovascular accident.

(Answers on page 611)



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10. Initiating Disciplinary Action Against Attorneys

The availability of additional tapes will be announced in the *ISMS Action Report* newsletter and the *Illinois Medical Journal*. ISMS ACTION CALL is another service made possible by funds from the special dues assessment voted in November, 1975, by the House of Delegates.



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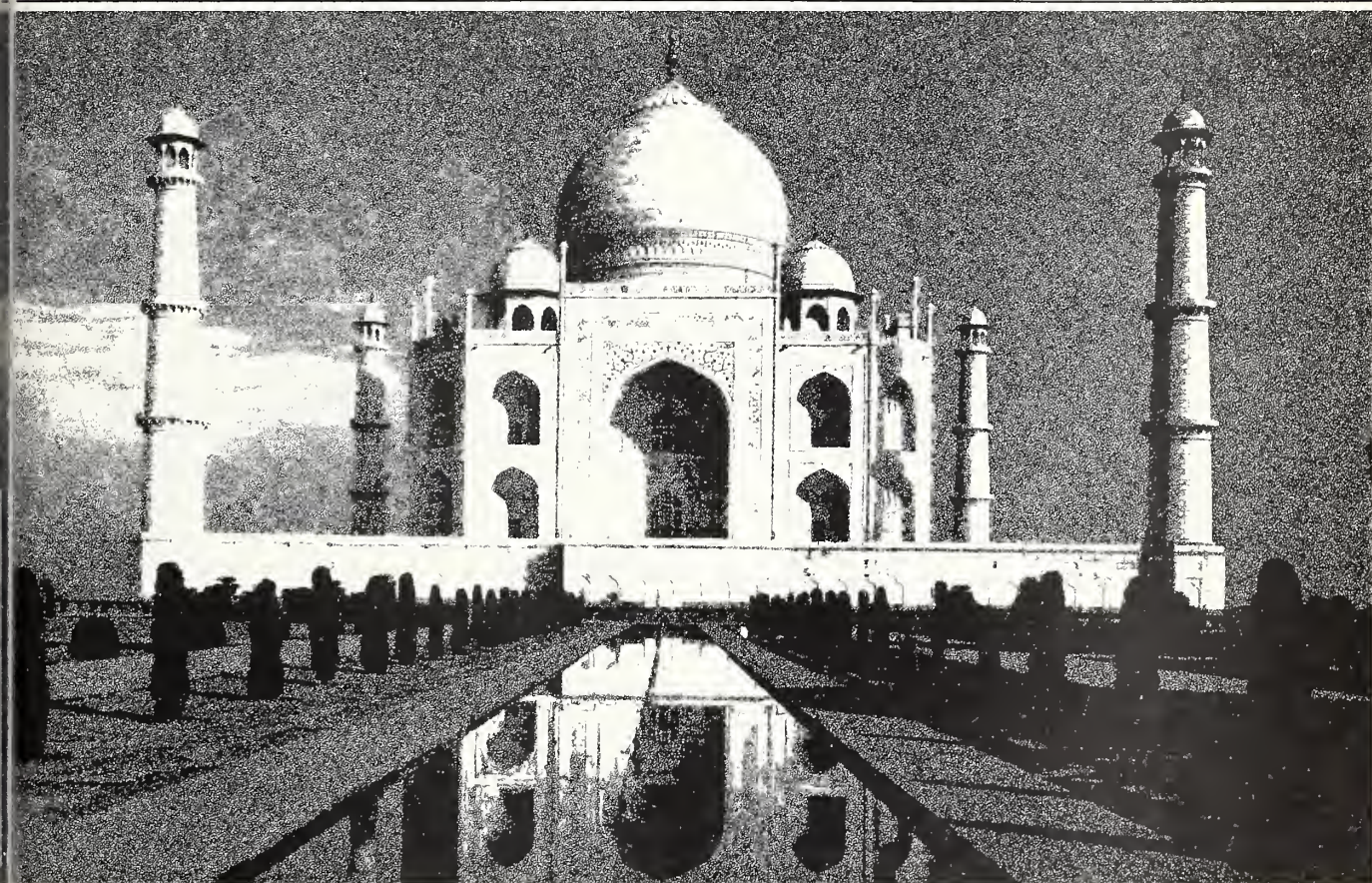
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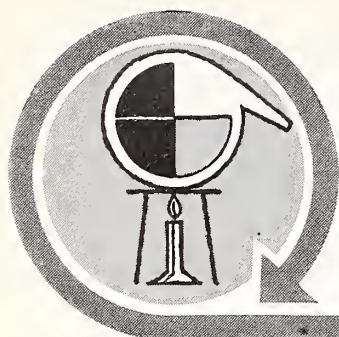
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# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

**The following new drugs have been marketed:**

## NEW SINGLE DRUGS

**AVITENE** Coagulant Rx  
 Manufacturer: Avicon, Inc.  
 Nonproprietary Name: Bovine corium collagen  
 Indications: Adjunct to hemostasis in surgical procedures  
 Contraindications: Closure of skin incisions  
 Administration: Apply directly to source of bleeding  
 Supplied: Sterile jars

**CeeNU** Cancer Chemotherapy Rx  
 Manufacturer: Bristol Laboratories  
 Nonproprietary Name: Lomustine (NSC 79037)  
 Indications: Palliative therapy in combination with other drugs in brain tumors and secondary therapy in Hodgkin's disease.  
 Precautions: To be administered only by individuals experienced in neoplastic therapy  
 Dosage: 130 mg/M<sup>2</sup> as a single dose every six weeks. Dose subsequent to initial dose adjusted to hematologic response  
 Supplied: Capsules, 10, 40 and 100 mg

**DANOCRINE** Hormone Rx  
 Manufacturer: Winthrop Laboratories  
 Nonproprietary Name: Danazol  
 Indications: Endometriosis amenable to hormone management  
 Contraindications: Undiagnosed abnormal genital bleeding, markedly impaired renal, hepatic or cardiac function, pregnancy or breast feeding.  
 Dosage: 400 mg bid, for 3 to 6 months, may be extended to 9 months.  
 Supplied: Capsules, 200 mg

**DURANEST** Local Anesthetic Rx  
 Manufacturer: Astra Pharmaceutical Products, Inc.  
 Nonproprietary Name: Etidocaine HCl  
 Indications: Percutaneous infiltration anesthesia and peripheral nerve blocks and central neural blocks  
 See package insert  
 Warnings: See package insert  
 Dosage: Multiple dose vial, 50 ml/0.5%  
 Supplied: Single does  
 vial, 30 ml/0.5 and 1%  
 Ampules 30 ml/1%  
 20 ml/1.5%  
 With and without epinephrine

**MINIPRESS** Hypotensive Rx  
 Manufacturer: Pfizer Laboratories  
 Nonproprietary Name: Prazosin HCl  
 Indications: Mild to moderate hypertension  
 See package insert  
 Warnings: Initial: 1 mg t.i.d.  
 Maintenance: raise dose slowly to 20 mg daily; some patients may require up to 40 mg daily  
 Supplied: Capsules, 1, 2 and 5 mg

## DUPLICATE SINGLE DRUGS

**CLOXAPEN** Penicillin Derivative Rx  
 Manufacturer: Beecham Laboratories  
 Nonproprietary Name: Cloxacillin Sodium  
 Indications: Infections due to penicillinase-producing staphylococci  
 Precautions: Those usual with penicillin type antibiotics  
 Dosage: Adults and children, 44 lbs and more: 250 mg q.i.d.  
 Children less than 44 lbs: 50 mg/kg/day in divided doses.  
 Increase dose with severity of infection  
 Supplied: Capsules, 250 and 500 mg

**DAXOLIN** Ataraxic Rx  
 Manufacturer: Dome Laboratories  
 Nonproprietary Name: Loxapine Succinate  
 Indications: Manifestations of schizophrenia  
 Contraindications: Comatose or severe drug-induced depressed states.  
 Precautions: Use with great caution in patients with convulsive disorders.  
 Usual therapeutic and maintenance dose—60 to 100 mg daily  
 Supplied: Capsules, 10, 25 and 50 mg



**NAFCIL** Penicillin Derivative Rx  
 Manufacturer: Bristol Laboratories  
 Nonproprietary Name: Nafcillin Sodium  
 Indications: Infections due to penicillinase producing staphylococci  
 Those usual with penicillin type products  
 Precautions:  
 Dosage: Adults: i.v., 500 mg q-4-h  
 i.m., 500 mg q-6-h  
 adjust to response of patient  
 Supplied: Vials, 0.5, 1 and 2g

#### COMBINATION PRODUCTS

**APRESAZIDE** Hypotensive Rx  
 Manufacturer: CIBA Pharmaceutical Company  
 Composition: Each capsule contains:  
 Hydralazine HCl 25 mg 50 mg 100 mg  
 Hydrochlorothiazide 25 mg 50 mg 50 mg  
 Indications: Hypertension, therapy requires titration of patients response  
 Contraindications: Coronary artery disease; mitral valvular rheumatic heart disease.  
 Dosage: One capsule b.i.d., strength depending upon individual requirement.  
 Supplied: Capsules

**NYSTAFORM-HC 1%** Topical Fungicide Rx  
 Manufacturer: Dome Laboratories  
 Composition: Each gram contains:  
 Nystatin USP 100,000 U  
 Iodochlorhydroxyquin 3%

Indications: Hydrocortisone 1%  
 Monilia and corticoid responsive dermatoses  
 Contraindications: Tubercular lesions of the skin, acute herpes simplex, vaccinia or varicella  
 Administration: Apply ointment bid or tid  
 Supplied: Tubes, 1/2 oz

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Manufacturer: Schering Laboratories  
 Nonproprietary Name: Betamethasone sodium phosphate  
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 Contraindications: Systemic fungal infections  
 Dosage: Initial up to 0.9 mg per day, depending on disease treated. Maintenance dose must be individualized, depending on patient's response.  
 Supplied: Ampules 1 ml/4 mg

#### ISORDIL TITRADOSE

Manufacturer: Ives Laboratories, Inc.  
 Nonproprietary Name: Isosorbide dinitrate  
 Indications: Prophylactic therapy of angina pectoris  
 Dosage: Adjust to requirement of patient  
 Supplied: Oral tablets, 5, 10 and 20 mg

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You should look into a tax-deferred

retirement plan at The Northern Trust Bank.

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### **Are you an employee not covered by a retirement or profit sharing plan where you work?**

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2,500	18,242.23	35,854.56	66,772.78	111,758.57	177,212.50	272,447.35
7,500	54,726.68	107,563.57	200,318.32	335,275.72	531,637.50	817,342.05

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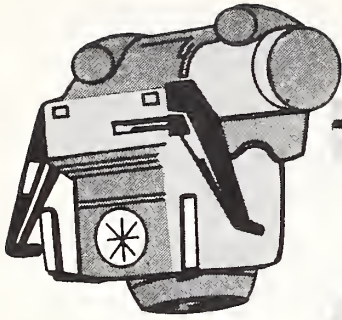
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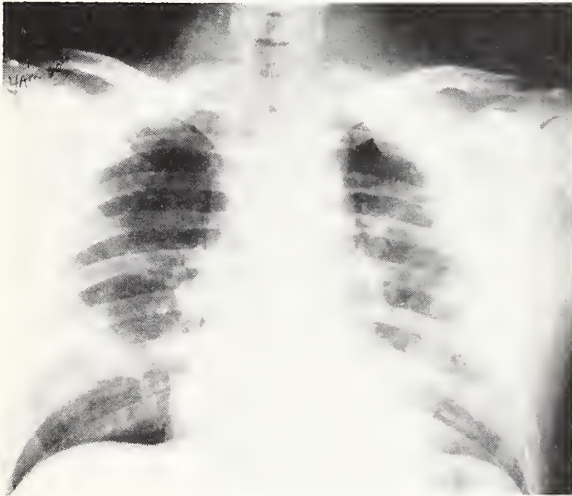
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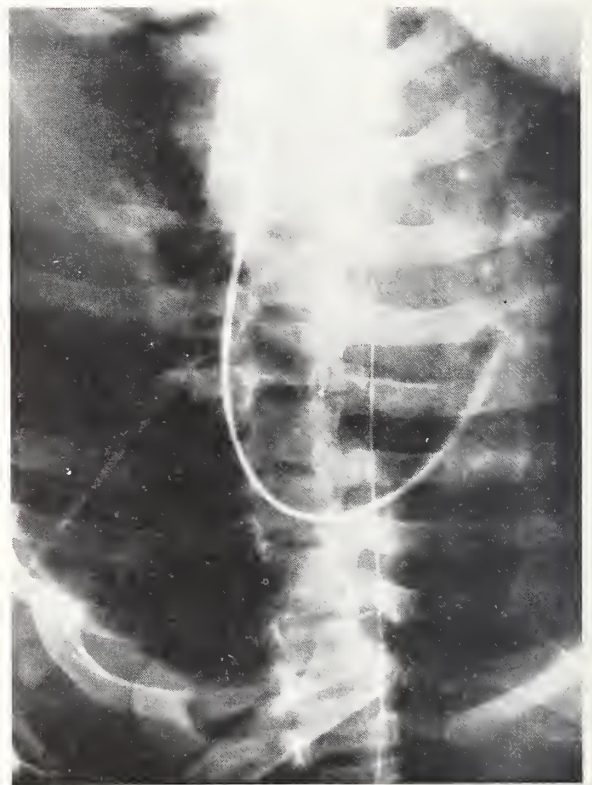
## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

A 23 year old male was brought into the Emergency Room following a head-on collision. His vital signs were reasonably good. There was some evidence of a drop in the hematocrit and the patient had radiographic evidence of rupture of the spleen. A chest film was taken as part of the routine examination, (Figure 1 and Figure 2).



**Figure 1**



**Figure 2**

*What's your diagnosis?*

*(Answers on page 604)*





# I M J

Illinois Medical Journal

Vol. 150, No. 6, December, 1976

## Extracranial Carotid Aneurysm — A Complication of Carotid Endarterectomy

BY NESTOR S. MARTINEZ, M.D., F.A.C.S./EVERGREEN PARK

*Extracranial carotid aneurysms occur infrequently and there is a paucity of reports of aneurysms occurring after carotid endarterectomy. A patient with post-endarterectomy aneurysm successfully treated prompted this report and review of literature.*

### Review and Perspective

Seven extracranial aneurysms of the carotid arteries were seen by Beall, et.al.,<sup>1</sup> among 2,300 operations for arterial aneurysms. Only eight carotid aneurysms were found by Houser and Baker<sup>13</sup> in 5,000 cervical angiograms.

The etiology of extracranial carotid aneurysms varies and a discussion of causes follows.

Bilateral spontaneous dissecting aneurysms of the internal carotid were described by Lloyd and Bahnson.<sup>18</sup> They were berry in type and associated with dysplasia of the media.

Aneurysms of tubular saphenous vein grafts after repair of carotid injury have been reported.<sup>6</sup>

Bilateral carotid aneurysms secondary to radiation therapy have been confirmed histologically with postirradiation changes and no arteriosclerosis. They occurred after treatment for malignancy of the head and neck.<sup>3</sup>

Carotid mycotic aneurysms<sup>23,10</sup> and those due to syphilis and tuberculosis<sup>14</sup> are less common now than in the past.

Buscaglia<sup>5</sup> and Brownstein<sup>4</sup> have observed carotid aneurysms subsequent to carotid angiography.

Posttraumatic aneurysms of extracranial carotid arteries were reviewed by Robinson and Floote<sup>22</sup> and their seriousness was emphasized by Whally.<sup>26</sup>

By far, the most common extracranial carotid aneurysms are due to arteriosclerosis. Of thirteen extracranial aneurysms described by Kaupp,<sup>15</sup> eight fusiform in shape were arteriosclerotic and five saccular were associated with degenerative changes of the arterial wall. Seven arteriosclerotic and one traumatic aneurysm were reported by Harding.<sup>11</sup>



NESTOR S. MARTINEZ, M.D., F.A.C.S., is the Senior Attending Surgeon, Thoracic Vascular Service at Little Company of Mary Hospital in Evergreen Park. Dr. Martinez holds an M.S. in Surgery from the University of Minnesota.

False aneurysms after carotid endarterectomy are rare among extracranial aneurysms but are of significant importance. In a series of 895 endarterectomies at the University of California, three false aneurysms were noted.<sup>8</sup> The authors collected cases from the literature and reported a total of 20 aneurysms; eight aneurysms followed endarterectomy and synthetic patch, seven followed endarterectomy alone, three occurred after endarterectomy and vein patch, one happened after resection and homograft, and one followed implantation of a synthetic tube graft. Recently, three more post endarterectomy aneurysms have been described.<sup>20</sup>

Post endarterectomy infection has been emphasized among other factors responsible for the formation of this post operative aneurysm.<sup>2</sup> In the absence of infection, suture disruption with leak and hematoma explains some aneurysmal formation.

False postoperative aneurysms may rupture, embolize, thrombose or become infected with the subsequent sequelae of these complications. Death and neurologic deficits due to carotid aneurysms are documented.

Formerly the treatment for extracranial carotid artery aneurysms consisted of proximal ligation of the artery. Carotid artery ligation carries an estimated risk of cerebral ischemia of 30%<sup>17</sup> and measurements of internal carotid artery pressure, cerebral blood flow and EEG have been used to predict patients susceptible to this ischemia. Nevertheless, arterial ligation is not recommended except when continuity of the carotid vessels cannot be restored. Resection of the aneurysm and arterial reconstruction is the method of treatment preferred.

If feasible, resection and end-to-end anastomosis is most desirable.<sup>19,16,1,23</sup> When end-to-end reconstruction is not possible, wrapping with fascialata,<sup>25</sup> bovine graft replacement,<sup>21</sup> anastomosis of internal to external carotid artery,<sup>27</sup> prosthetic graft or autogenous graft replacement have been recommended.

In the surgical treatment of postendarterectomy aneurysms, resuture alone or with a synthetic or autogenous patch also has been used when anatomic conditions permitted.<sup>8</sup>

During resection and reconstruction, prevention of ischemic brain changes has been attempted in different ways. Hypercarbia and hypothermia have been used but are largely abandoned. Internal shunt bypasses have been recommended to decrease the risks resulting from carotid occlusion.<sup>9</sup> External shunts to bypass the aneurysm

have been recommended from the axillary to the internal carotid<sup>24</sup> and the aorta or innominate artery to the internal carotid above the aneurysm.<sup>7</sup>

### Case History

L.S., a 66-year-old white male patient, was admitted to Little Company of Mary Hospital for transient ischemic attacks of three weeks duration.

He complained of episodic spells of dizziness in which he would lose his balance and which were associated with blurred vision of the left eye. These symptoms would last about five minutes and subside completely. He complained also of precordial pain and ankle edema. On physical examination, the pupils were equal and fundi were normal. His blood pressure was 160/90, with regular pulse. Neurological examination was normal. The left carotid pulse was decreased and there was a harsh carotid bruit on the left. Other peripheral pulses were normal.

Chest X-ray, SMA 12, CBC, urinalysis and IVP were normal. Triglycerides and cholesterol were within normal range. X-ray of the colon revealed diverticulosis. The EKG showed occasional premature ventricular systole. Treadmill Exercise



Figure 1

Direct puncture left carotid arteriogram shows stenosis of internal carotid artery and stenosis of common and external carotid artery.



Test was abnormal at 124 beats per minute with ischemic ST segment depression and retrosternal pain. On 11-10-75, a right retrograde brachial and a left carotid puncture arteriogram were performed (Fig. 1). They showed 2.5 cm. stenosis of the left internal carotid and common bifurcation with 90% occlusion. A 10% carotid stenosis was present on the right carotid bifurcation. The intracerebral circulation was normal and both anterior cerebral arteries appeared to fill from the right carotid system.

A left carotid endarterectomy with Dacron angioplastic patch and Dacron sutures was done uneventfully on 11-15. The stenotic plaque extended 2 cm. on the internal carotid artery. Postoperative recovery was uneventful and the patient was discharged on 11-19.

Two weeks after the operation, the patient noticed an enlargement at the site of the endarterectomy and he complained of pain. Antibiotics were prescribed. Progressive enlargement of the left neck mass to 8 cm. in diameter prompted hospitalization eight weeks after initial surgery.

On readmission 1-26, there was severe pain on the left neck, progressive hoarseness and enlargement of the mass. His temperature was 100.6°F. Discoloration of the skin with a blue tinge and thinning over the pulsating mass suggested impending perforation (Fig. 2). There was no evidence of cellulitis or infection. Tetracycline 250 mg. four times a day was given. Other



**Figure 2**

Anterior view of neck reveals left internal carotid aneurysm after endarterectomy. Note thinning and discoloration of skin with impending rupture.

antibiotics were contraindicated because of previous allergies.

Two days after admission an aortic arch arteriogram (Fig. 3) revealed a 4 x 3 cm. aneurysm of the common and internal carotid arteries. The left internal artery was visualized suggesting no obstruction and possible need of cerebral perfusion during operation. Four days after admission, on January 30, an operation was performed for an impending perforation of left carotid artery aneurysm.



**Figure 3**

Aortic root arteriogram eight weeks after endarterectomy. Note large aneurysm involving internal, external and common carotid arteries.

Separate skin incisions in the supraclavicular and submental regions permitted isolation of the proximal common carotid and distal internal carotid arteries.

To avoid hemorrhage and cerebral anoxia, a temporary external bypass shunt (Fig. 4) was placed between these vessels before entering the aneurysm. The common carotid was isolated behind the left clavicle and the internal carotid artery was isolated above the digastric muscles avoiding the site of the aneurysm and possible



Figure 4

Left carotid aneurysm intact in the center of picture. External shunt with bypass from low common carotid to high internal carotid arteries prior to attack of rupturing aneurysm.

site of infection. The lingual, hypoglossal, facial, vagus, and spinal accessory nerves were all identified and preserved. This bypass functioned for the time required for the resection of the aneurysm and the reconstruction with saphenous vein.

Pathologically, the aneurysm was false in nature with failure of the posterior wall suture between the angioplastic patch and the internal carotid artery wall. Cultures of the patch and hematoma revealed staphylococcus epidermis.

Most of the common, external and internal carotid arteries were resected and a tubular graft of left saphenous vein was used to repair the 10 cm. defect between the common carotid artery and the internal carotid artery above the hypoglossal nerve.

No neurological deficit occurred in the postoperative period which was uneventful except for a mild infection of the saphenous vein donor site. Blood cultures were all negative in the postoperative period.

### Comments

The potential severe danger of extracranial aneurysms in general, and that of postendarterectomy aneurysms in particular, requires treatment of these conditions.

Resection of the aneurysm and reconstruction of continuity of the carotid arteries is the treatment of choice. Tubular saphenous or prosthetic grafts are useful to bridge defects created by resection. Autogenous tissue is preferred.

Prevention of transient or permanent ischemic brain changes due to carotid occlusion is important. Embolization of thrombus, debris, blood clots, or bacteria should be avoided during operation. Massive hemorrhage should be prevented. External carotid bypass as described is a valuable technique in accomplishing these purposes while maintaining cerebral perfusion. It may be superior to internal bypass in preventing embolization.

Aneurysmorrhaphy, resuture of artery or patch and application of a new patch have all been successfully used under suitable circumstances in treating postendarterectomy aneurysms.

Ligation only of carotid vessels proximal to the aneurysm is best reserved to cases where resection and reestablishment of continuity are not feasible.

To determine the safety of carotid occlusion, measurement of the internal carotid artery pressure, evaluation of electroencephalogram, and cerebral blood flow studies during vessel clamping, may be of value. ◀

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# Emphysematous Cholecystitis

By PRAFUL H. AMIN, D.M.R.D., F.R.C.R./CHICAGO

*Two cases of emphysematous cholecystitis are described. Although there are certain differences in the clinical presentation of this condition from the usual forms of acute cholecystitis, the only definitive diagnostic features are radiological.*

The first description of emphysematous cholecystitis is attributed to Welch and Flexner.<sup>1</sup> They reported an autopsy finding of cholecystitis caused by *Clostridium perfringens*. The disease has been described as acute pneumocholecystitis, gas forming cholecystitis, cholecystitis emphysematosa, acute gaseous cholecystitis, pyopneumocholecystitis, pneumogenic cholecystitis, gas phlegm of the gallbladder and gangrenous chole-

cystitis. This type of cholecystitis is associated with a higher mortality than is the case with the other forms of gallbladder inflammation.

## Case Reports

**Case I:** Male, age 77, admitted as an emergency in May, 1970, with severe right-sided abdominal pain and anorexia. There was no vomiting. He was dehydrated with a pulse rate of 120 per minute and B.P. 150/100. There were signs



Figures 1 a and b (Case I). Supine and erect radiographs of the abdomen.



PRAFUL H. AMIN, M.D., F.R.C.R. is a fourth year resident and instructor in Radiology at University of Illinois Hospital. Dr. Amin is specifically interested in gastrointestinal radiology, angiography, and echography.

of generalized peritonitis with direct and rebound tenderness on the right side. Radiographs showed free air under the right diaphragm and a fluid level in the gallbladder. There was a lucent halo around the gallbladder which was gas dissecting its wall. (Fig. 1a,b,c.)

At laparotomy free fluid and air were found in the peritoneum. The gallbladder was acutely inflamed and had perforated at Hartmann's pouch resulting in peritonitis.



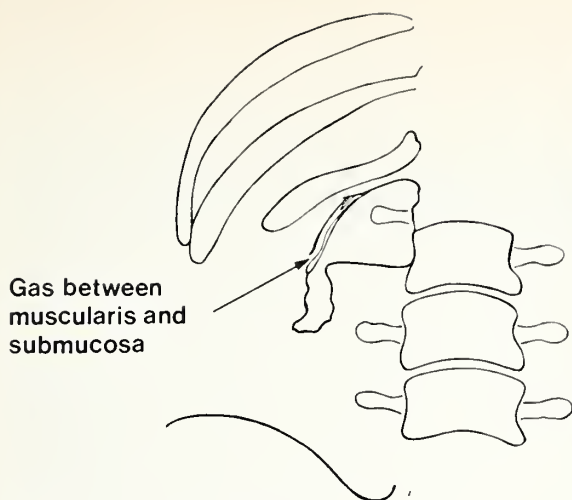


Figure 1 c. Line drawing of Figure 1 b.

Note that the gas streaks extend lower than the fluid level thus confirming their location.

A cholecystectomy was performed and the gallbladder bed drained. Culture produced *Cl. welchii* organisms. The post-operative course was complicated by atrial fibrillation and bronchopneumonia both of which settled with treatment.

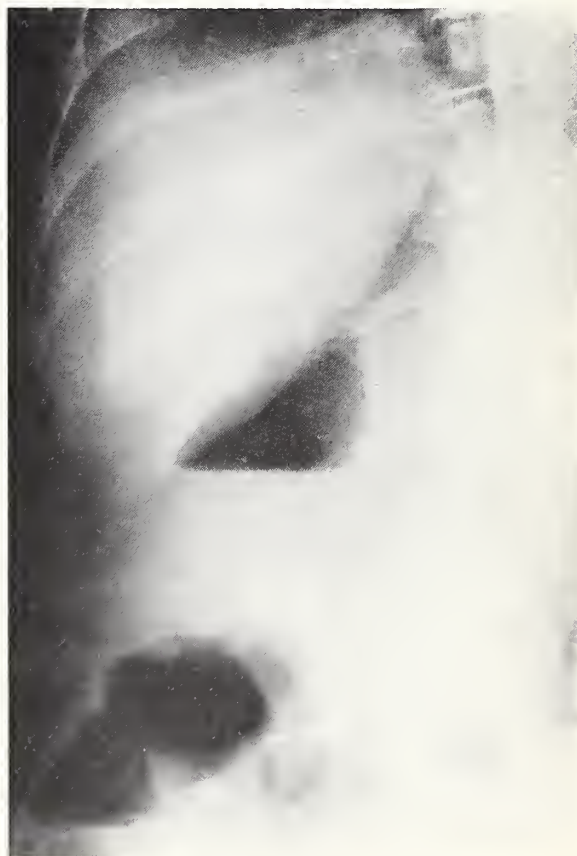
**Case II:** Female, age 63, admitted as an emergency in July, 1963. She complained of increasing abdominal pain for five days. The pain started suddenly following a meal and was accompanied by vomiting. Later the vomiting stopped but the pain became progressively worse. Four hours prior to admission she felt pain at the tip of the right shoulder. Previous health had been good except for angina and there was no history of diabetes or jaundice.

On examination she was obese and mildly dehydrated. The temperature was 37.2°C., B.P. 150/95 and the pulse rate 100 per minute. There was abdominal rigidity with direct and rebound tenderness in all quadrants. No mass was felt. Radiograph of the abdomen showed gas in the biliary tree and a fluid level in the gallbladder (Fig. 2a,b.) A communication between the gallbladder and bowel or alternatively infection with gas forming organisms was inferred. No gall stones were seen. At operation a gangrenous gallbladder with biliary peritonitis was found and cholecystostomy performed. Abdominal pain recurred following operation culminating in vomiting, fever, dark urine and pale stools. There was one episode of jaundice. An intravenous cholangiogram showed normal ducts but very faint opacification of the gallbladder.

At operation in October, 1963, the gallbladder was found to be small, fibrotic and adherent to the surrounding structures. It was excised but the common bile duct was not explored. She made a slow but satisfactory recovery.



Figures 2 a and b (Case II). Supine and erect radiographs of the abdomen.



## Discussion

Emphysematous cholecystitis is a rare condition due to infection by gas-producing organisms. The gas is produced in the lumen and within the wall. Organisms of the Clostridia group, Streptococcus faecalis, other aerobic and anaerobic streptococci, Ps. Pyocyanea and atypical gas producing Actinomyces have been incriminated. Clostridia welchii is the most commonly found organism either alone or in combination with E. Coli.

The clinical picture is that of a severe acute cholecystitis. Falconer et. al.<sup>2</sup> observed that these patients were more toxic and ill than could be accounted for by the clinical findings. Sherlock<sup>3</sup> has stated that the patients with acute gangrenous cholecystitis are toxic and ill. Possibly in acute emphysematous cholecystitis the gangrenous state of the gallbladder is responsible for this increased toxicity.

There are differences from classical acute cholecystitis. A higher incidence in men than in women<sup>4-7</sup> and a peak age incidence in the 6th and 7th decades has been noted. Diabetic patients appear to be more prone to gallbladder infection by gas-producing organisms and almost 30% of the reported cases have this association.<sup>5,6</sup> A palpable mass is more frequently found than in other forms of acute cholecystitis. Bigler<sup>8</sup> in fact reported an incidence of 42%. Nausea is common in cases of acute cholecystitis but vomiting is more frequent in emphysematous cholecystitis, said to be associated with common bile duct obstruction. These features, while they demonstrate the variations from typical cases of acute cholecystitis, are in no way diagnostic. A definite diagnosis can only be made on the radiological appearances.

## Radiology

The radiological appearances may be diagnostic. Plain radiographs will show gas in the gallbladder which is usually enlarged. A radiograph taken with the patient erect or in the lateral decubitus will show a fluid level. If perforation of the gallbladder or cystic duct has occurred, free air in the peritoneum may be demonstrated. Accumulation of gas within the gallbladder will usually be visible within 24-48 hours.<sup>9</sup> Gas dissecting between the muscularis and the mucous membrane produces a thin lucent halo around the gallbladder at first near the fundus, but gradually extending around the viscus. (Fig. 1a,b,c) This appearance was first described by Hegner.<sup>11</sup> The presence of a well-formed halo or numerous crescentic streaks is diagnostic of cholecystitis

caused by gas-producing organisms. In advanced cases the gas may pass into the tissue around the gallbladder, but presence of gas in the pericholecystic tissue does not necessarily imply a gangrenous gallbladder. In fact these patients may recover even without surgery.

In Case I, the characteristic halo around the gallbladder is shown. Presence of gas in the bile ducts has also been reported,<sup>12-14</sup> but this is an uncommon feature. Gas in the bile ducts alone is unlikely to be due to emphysematous cholecystitis and some other cause should be sought.<sup>15</sup>

As the disease progresses the quantity of gas within the lumen of the gallbladder may diminish but that in the wall and in the pericholecystic tissues persists and may even increase.

## Differential Diagnosis

Gas in the biliary tract from incompetence of the sphincter of Oddi or cholecyst-enteric fistula should present little difficulty since they do not present an acute abdominal emergency and intramural gas is not found. In cholecyst-enteric fistula, the gallbladder is usually collapsed. A gas filled duodenal cap or gastric antrum are readily differentiated by barium studies. An extrabiliary abscess in the right hypochondrium may cause difficulty in differentiation and the presence of normal gallbladder function will exclude cholecystitis. A gas halo around the lumen of the gallbladder is diagnostic of emphysematous cholecystitis.

## Treatment

There is a high mortality in this condition reaching 10-12%.<sup>14</sup> A perforation is of a serious consequence and the mortality in these cases rises to 40-60%. Cholecystectomy is the operation of choice and should be undertaken when the general condition of the patient permits. Evidence of spreading peritonitis indicates the need for prompt surgical intervention. All patients should be started on intensive antibiotic therapy as soon as the diagnosis is made. The choice of operation and its timing will depend on the clinical state of the patient. ◀

## References

A list of references for "Emphysematous Cholecystitis" may be obtained by writing *IMJ*, 55 E. Monroe, Suite 3510, Chicago 60603.

## Acknowledgement

*I wish to thank Dr. I. Hyde for his advice and encouragement in the preparation of this paper, and Dr. F. J. Brunton for permission to publish the second case.*



# Letters to the Editor

## SIDS: WORKING A MODEL

*To the Editor:* In recent years we have methodically re-evaluated post mortem, epidemiologic and research findings, and constructed a model of the SIDS entity consisting of input parameters from across various disciplines.<sup>1,2,3,4</sup> Sound methodology dictates that accumulating data and knowledge be incorporated into a continually refined working model in order to rule out some directions of search, narrow the field of possibilities and to govern subsequent work. A construction of this nature is the only defensible yardstick against which hypotheses can be judged with regard to plausibility and merit. Research efforts which follow leads based on groups of isolated facts, and "island hypotheses" which ignore contradictions evident in the larger picture of the death entity, have been the cardinal pitfalls of misguided zealots and experts alike, and lie at the base of our failure to affect sustained increments of progress in any given direction for solution to the problem. The following is a critique on Tonkin's<sup>5</sup> hypothesis of oro-pharyngeal airway obstruction consequent to displacement of a hypermobile mandible, and follow up study by Kravitz and Scherz<sup>6</sup>, relative to our working model.

There is a gratuitous assumption that once the mandible, tongue and soft palate move posteriorly to obstruct the airway, they will remain fixed in that position by physical vectors and the force of gravity much as a collection of inert blocks. The concept of an infant as a *reacting organism* is basic to the understanding of behavior. There is no good reason to suppose that infants will not react to the distress generated by internal occlusion to the air supply any less vigorously than they do to an external block of the airways.

Most infants can lift up their heads with the body in a prone position during the peak of the SIDS age range. Only a mild to moderate effort is required at that stage to roll the head to

either side and enable the force of gravity to unlock the airway. Should some infants fail to make the minimal adjustment required, it would seem that the vigor of the agonal struggle would suffice to dislodge the anatomic structures constituting the occlusion to save their lives.

Secondly, our studies rule out the likelihood of a unilateral force, especially a force which is static in nature, as sufficient to take the life of a thriving youngster. The model indicates suffocation to be a dynamic process which finds the glottis trapped in a closed system between the sustained action of two systems working in opposition to each other:

"... a rush of gas is halted abruptly in the throat, the membranes of the pharynx are acutely expanded under the resistance encountered, and the swallowing reflex (with recruitment of other mechanisms) is triggered. These lock the throat in a tighter grip by potentiating the seals against the external air supply, respiration is inhibited, and contraction of the throat walls generates esophageal action in opposition to reverse peristaltic flow. With pressure maintained along the length of the esophagus by the unexpelled reservoir of gas still pressing for release from the stomach, and the sustained action of a throat in spasm, *both ends of the system continue to work against the middle until the child is suffocated.*"<sup>3</sup>

This is a death mechanism which involves "loaded" systems capable of independent discharge, and tissues which will not readily yield to an infant's musculoskeletal thrashings in the horizontal position.

Tonkin and others apparently still hold to the concept that "Sleep is a necessary concomitant of cot deaths . . .".<sup>5</sup> Kravitz and Scherz cite statistics on the number of infants who "were put to bed on their stomach with the face to one side and were found to be face down when the SIDS was discovered," and join Tonkin in proposing that, "in the face down and prone position a hypermobile mandible would be vulnerable to displacement by pressure from the infant's own head weight on the mattress."<sup>6</sup> Our

model refutes both assumptions:

"We can only be certain that it is the sleeping position which accompanies SIDS. More likely once the throat is engorged with gas and paralyzed, the infant is awakened by pain as well as need for air. It struggles as best it can and strangles silently, unable to utter a sound because air cannot be moved in either direction over the vocal cords. Once lifeless, the throat and its cavities relax, releasing the trapped air and leave no sign of the killer. And it is this final discharge of gas which carries with it the bloody froth or mucous often found in the nose or mouth of the victim. Tell-tale signs of an internal paroxysmal struggle, the pulmonary and gastrointestinal forces acting in opposition to each other, are regularly observed on autopsy and manifested by moderate inflammation of the mucosa at the juncture where both passages meet. With the pharynx blocked, only a U-turn exists which affords limited vacillation (and mixture of gases and material) between both passages. This is why curd at times is found in the trachea and major bronchi."<sup>3</sup>

The point to be made is that it is *not* the face down position which triggers SIDS but rather the reverse. It is the terminal struggle and/or seizure state which serve to draw the infant's head from the side and into line with the prone body, and in a large number of cases the face down attitude is maintained into rigor mortis.

Finally, if the semi-reclining sleep position advocated by Kravitz and Scherz proves to be "safer" than the horizontal, it will not be a matter of mandible displacement, but rather a consequence of improved neck alignment and/or the alteration of pathways in the throat to better enable the release of more intense discharges generated by the walls of the stomach. Our original paper<sup>1</sup> focuses on the multiplicity of factors which render the neck a feckless link between the shifting weights of the head and trunk, and the delicate passageways within a target for overloading or decompensation in reaction to the driving force of gas expelled by the stomach. Our model indicates a solution to the SIDS problem relative to that target area will be found, and we are now completing a study which points to a likely preventative measure.

KARL J. KADLUB, Ph.D.  
K. GREGORY KADLUB, B.S.  
Battle Creek Sanitarium Hospital  
Battle Creek, Michigan

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*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 18, 1976.*

## Case Report: Tuberculoma

**Dr. Ivar Szper:** A 62-year-old white male, a heavy drinker and smoker, was considered to be in good health, enjoying fishing and golfing until November, 1975, when he had the sudden onset of coughing, confusion, and weakness while in Alabama. His sputum was positive for AFB. Tuberculosis was confirmed by chest X-ray and further sputum examinations. He did not have a history of tuberculosis in his youth. Further diagnostic studies demonstrated chronic obstructive lung disease.

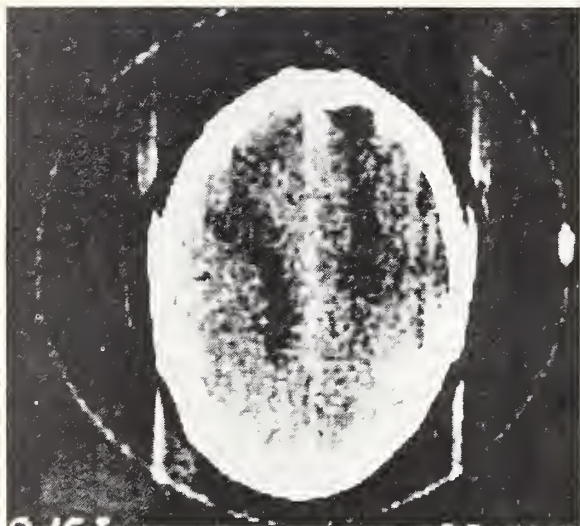
On Feb. 29, 1976, he fell and appeared to be more confused but neurological deficits were not noted. The patient was then transferred to the local VA hospital for chronic care. Thirty-six hours after his transfer, a neurology consultation was obtained because the patient's confusion increased and progressive lateralizing neurologic signs appeared. Examination at that time showed an enlarged right pupil and ptosis on the right, a right central facial right hyperreflexia, right Babinski, with the patient generally confused. The diagnosis at that time was a left subdural hematoma with mid brain compression at the temporal notch. This was considered secondary to his fall.

The patient was then transferred to the VA Lakeside Hospital for angiography. A cerebral angiogram was done on March 3, 1976 and

showed some abnormalities, which could be either an anomaly for the patient's age or possibly space occupying mass, but a subdural hematoma was not present. A CAT scan was recommended; however, the patient was transferred back to the other VA hospital.

Three days later, the patient developed meningismus, increased lethargy, hiccups, right hemiplegia, and left hemiparesis. A presumptive diagnosis of tuberculosis meningitis was made. Lumbar puncture performed at the time showed opening pressure of 270; closing pressure of 150. Protein was 96 mg % and clear and colorless; chloride was normal. CSF was negative for acid fast bacilli. Brain scan performed on March 15 was normal. EEG performed showed some slow waves on the left frontal parietal region. A repeat brain scan on April 2 showed bilateral increased uptake in the occipital region, but was not specific. A CAT scan showed increased uptake with infusion, strongly suggestive of a primary neoplasm or metastasis, in the left parietal region. (Figure 1)

The patient was then transferred back to the VA Lakeside Hospital for definitive treatment. Examination at that time showed him to be afebrile with normal pulses, pressure and respirations. He was poorly developed; he was cachectic and acutely ill. Neurologically, he was quite con-



**Figure 1**  
Computerized axial tomography demonstrated increased isotope uptake in left parietal, suggesting neoplasm.

fused, lethargic, and incontinent. His vision was decreased, secondary to cataracts. He had a sluggish left pupil, right central facial paresis and right hemiparesis with the arm affected greater than the leg. There also appeared to be clonus of the right ankle. He had parietal lobe signs, suggested by the fact that he could not recognize his family. He did not have meningismus. Laboratory data: elevated serum alkaline phosphatase and SGOT levels, normal hemoglobin and hematocrit were present. White blood count was 8,000.

### **Surgical Specimen**

On April 28, a left parietal temporal craniotomy was performed and a grape-sized tumor was removed. It was pale and hard and was surrounded by a mass of edema. This lesion was a tuberculoma, situated subcortically in the angular gyrus. Microscopically, acid fast organisms were seen. The lesion was difficult to locate because of its small size and its whitish color. Initially, the patient was thought to have a glioblastoma because of the texture of the edematous brain.

**Dr. Imre Almasy:** Figure 2 represents a projection obtained during a direct left carotid artery injection. The anterior cerebral artery is in the midline; later films showed no shift of the internal cerebral vein. The middle cerebral axis is slightly higher when compared to the right side and the lateral view reveals the Sylvian point to be slightly anterior to the other side.



**Figure 2**  
Carotid arteriogram shows abnormal vascularity in the posterior parietal area, left side.

There is also some questionable separation of the parietal, occipital and angular branches on the left side. No tumor vessel, tumor stains or early veins are identifiable.

On the basis of these findings, we made a diagnosis of an avascular space occupying lesion, without being able to differentiate between tumor, abscess or other lesions. An EMI scan was obtained for further evaluation. The examination was not satisfactory and was incomplete because of motion artifacts. Nevertheless, there was evidence of previous surgery in the left parietal region. The preinfusion scan revealed an area of low density in the posterior parietal region. The postinfusion scan is incomplete but revealed a ring of increased radiodensity, apparently enhanced with contrast material, in the same region. This finding is nonspecific and it is not clear whether it represents an abscess or is related to previous surgery or an infarction.

**Dr. Hidejiro YoKoo:** Examining the excised specimen, we found that the lesion was quite typical of a tuberculoma. It had almost a spherical configuration, measuring approximately 1 cm in diameter. The outside looked fairly firm and when we bisected the nodule, there was a thin shell of tissue which had a rubbery consistency. The central portion of this nodule consisted of dry, cheese-like, pale yellow material. This material was not quite like an abscess, because in abscess you have a more liquified material. A photomicrograph showed the shell por-



tion of the specimen. It consisted mostly of cerebral cortical tissue. Within the cerebral tissue is a narrow zone of granulomatous tissue consisting predominantly of capillaries, histiocytes, giant cells and numerous inflammatory cells, which are mostly a mixture of lymphocytes and plasma cells. There are a few polymorphonuclear leukocytes, particularly toward the center of the lesion, indicating that there may still be an active process going on. The cerebral tissue also contains increased numbers of glial cells which represent a reactive phenomenon. Adjoining the granulomatous tissue, there is an extensive area of caseating necrosis. This histology is quite typical of what we see in the tuberculous granuloma. Acid fast bacilli were identified in the sections stained for the organisms.

### Pathology

**Dr. Ivar Szper:** At the turn of the century, the most common brain tumor reported in the literature was tuberculoma but with the advent of streptomycin, and improved public health, the reported figure is now about 0.5-1% in North America. In other countries, perhaps about 30% of the primary diagnoses for space occupying tumors would be a tuberculoma.

Various authors have found the incidence of intracranial tuberculoma dependent upon the country. The incidence in the United States is 0.5%; India, 20%; Latin America, 3%; Chile, 15%. Tuberculomas occur more commonly in patients under the age of 20, with a predominance in females, approximately three to one. The posterior fossa is the usual location and the patients show a slowly progressive neurological deficit. One study indicated that 39% of the patients had signs of tuberculosis elsewhere involving other organs and that 36% have had a previous history of contact with tuberculous patients. In general, those patients with neurologic signs who appeared to be in a better nutritional condition had tuberculomas rather than tuberculous meningitis. In another study, most of the patients presented with malaise, lethargy and increased temperature. In comparison to patients with gliomas, convulsions lateralized to the side of the lesion, while in patients with tuberculomas, convulsions did not lateralize significantly.

These lesions are considered indistinguishable, clinically and radiographically from other space occupying masses. The examination of the cerebrospinal fluid is not diagnostic. Brain scans are variable in diagnostic assistance because 16-30% have proven multiple deposits. Angiographically,

an avascular mass is detected in 80-95% of the cases. Five percent of the cases have a sudden decrease in the caliber of the vessel size. Tuberculomas may resemble a meningioma because they may have an arterial supply from the external meningeal vessels. Vessel displacement was markedly abnormal in our patient. This actual tumor was approximately one centimeter in diameter but the edema was at least 10 to 15 centimeters in diameter. Many times the tuberculomas are calcified. CAT scans are quite helpful because specific localization of the tumor can be obtained.

All patients who have tuberculomas now should be operated upon. Chemotherapy should be instituted immediately and, if at all possible, a few days of treatment should precede their extirpation. Multiple deposits may be noted arteriographically, but only the one causing the symptom should be removed. If it is suspected that the patient has an infiltrating tuberculoma not well encased, operation should be delayed and he should have tuberculous therapy first. Since streptomycin has been available, direct surgical intervention has been more successful. Formerly, patients usually died within three to twelve weeks, secondary to obstructive hydrocephalus. This is due to the fact that the meninges became contaminated and obstructed the aqueduct or the fourth ventricle. Doctor Cushing did only decompressive operations so as not to disturb the brain. Dr. N. Store tells me that he saw in Boston a man of 80 years that Doctor Cushing had so treated. In recent studies, of 107 patients with tuberculomas, only three developed postoperative tuberculous meningitis. These patients should be started on Streptomycin, Rifampin, Ethambutol, Pyridoxine, Vitamin B complex or INH, or a combination of three of these drugs, given as prescribed per body weight per day.

Any ventricular peritoneal or ventricular atrial shunting should not be performed because this will lead to miliary tuberculosis.

### Cultural and Geographic Aspects

Thus, this is a rare problem in the Western hemisphere. Triple drug therapy should be instituted prior to surgery. The amount of edema caused by the tuberculoma is out of proportion compared to the size of the actual tuberculous lesion.

**Dr. Nicholas Wetzel:** This really is a rather rare type of lesion in this country, as Doctor Szper said. However, it is fairly common in India; in fact, it has been the most common intracranial

tumor in India. As you know, there are a lot of cows in India and, while they don't eat the meat, they do drink the milk. I think tuberculosis in general is a very complex disease, having to do not only with the social-public health aspects, and with the geographic aspects, but also in the reaction of the particular patients to the disease. Tuberculosis seems to have different effects in different parts of the country and the world. It used to be thought, for example in England, where the cows weren't carefully inspected, that there was lots of tuberculous meningitis. In this country, tuberculous meningitis is rare due to the fact that tuberculin testing of cattle has been carried out for a long time. Other manifestations of tuberculosis are varied in other places. In the southwest Pacific, tuberculosis was and is the commonest of tropical diseases. I saw patients there who had scrofula and tuberculosis peritonitis, but no patients had central nervous system tuberculosis.

At Cook County Hospital during the last three or four years, they have seen perhaps two or three tuberculomas, although they treat a number of patients with tuberculous meningitis. So,

even though tuberculosis is not uncommon in the County Hospital population, tuberculomas are. One of the real problems in a patient such as this is the problem of blood-brain barrier. Most antituberculous medications do not cross the blood-brain barrier. In the case of tuberculous meningitis with the meninges inflamed, there is good passage; however, if a patient doesn't have meningitis, the chances of achieving adequate central nervous system levels of antituberculous medication are not good.

When I was a resident, I had the interesting experience of treating a patient with tuberculous meningitis. At that time, Sir Hugh Carns, the famous British neurologic surgeon, had become very interested in tuberculous meningitis and had visited us here at Northwestern. This patient was on a regimen of getting oral medications and of intrathecal streptomycin and tuberculin, the latter to prevent meningeal reaction and hydrocephalus. I did daily lumbar punctures over a period of months and was rather frightened of getting tuberculosis myself by inadvertently pricking my finger. ◀

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# Social Setting Alcohol Detoxication

## A Chicago Model

BY JAMES W. WEST, M.D./CHICAGO

The treatment of acute alcoholism is a medical process which includes identifying the condition, assessing its urgency and making a disposition of the case. Acute alcoholism, defined as any degree of acute intoxication from alcohol, or one of the stages of the withdrawal syndrome, occurs at all levels of society. The vast majority of persons with this condition recover in their homes; rarely are they sufficiently sick to be admitted to a hospital. However, the treatment of acute alcoholism in those areas of the city where there occur concentrations of persons classified as the "homeless inebriate," presents unique problems hitherto handled in Illinois by the criminal justice system. Specifically, the police would pick up the public inebriate who was incapacitated in a public place, and after determining that he did not require hospitalization, would place him in the jail on a charge of public intoxication. Very few persons required hospital care so the jail, or "drunk tank" was the place where these homeless persons were housed. This system prevailed until the implementation of the Alcoholism and Intoxication Treatment Act (PA 78-1270)<sup>1</sup> in Illinois, on July 1, 1976. This act states, in effect, that alcoholism and intoxication are concerns of the health care system rather than the criminal justice system.

The new law demanded that the public inebriate be taken to a health care facility rather than the jail, and since few require hospital care, a new solution had to be designed. This solution took the form of the Social Setting Detoxication Center.

The concept of non-hospital, non-drug detoxication centers originated in Canada<sup>2</sup> and was further developed in California.<sup>3</sup> The purpose of the detoxication facility is detoxication and referral. It has a unique staffing pattern of trained persons, and exists in an alcoholism treatment network which includes the general hospital with which it has a close contractual relationship. It must be considered a medical facility inasmuch as its method of operation is clinical, and, with regard to alcoholism, it is an extension of the general hospital emergency room. The social setting detoxication facility and the back-up general hospital are intrinsic components of a network<sup>4</sup> which also includes rehabilitation centers, out-patient programs and vocational rehabilitation facilities.

The Chicago model of this concept of care is called Haymarket House, located at 12 South Peoria Street, serving the area of West Madison Street, a long time "skid row" section. The facility is operated by the Chicago Clergy Association for the Homeless Person, Inc. It was founded to function as a demonstration project by a private grant from the Chicago Community Trust, for the six month period before the implementation of the law PL 78-1270. Since July 1, 1976 the facility operates by a grant from the Illinois Department of Mental Health and Developmental Disabilities.

Haymarket House operates at two organizational levels, administrative and clinical. The administrative organization expedites the functions of the house and handles its relationships with the outside agencies, hospitals, and referral sites. The clinical staff of the house consists of



JAMES W. WEST, M.D., is an Assistant Professor in the Department of Psychiatry at Rush-Presbyterian-St. Luke's Medical Center. Dr. West is Medical Consultant for Haymarket House in Chicago, and Co-Chairman of the ISMS Committee on Alcoholism and Drug Abuse. He also is a surgeon at Little Co. of Mary Hospital, Evergreen Park.

triage and detoxication technicians and alcoholism counsellors. The clinical staff undergoes an initial training and this continues at a bi-monthly period. The training and clinical competence levels are the responsibility of the Medical Consultant. The clinical personnel are recovered alcoholics, most of whom have had some experience in a "skid row" setting. The training follows a specific format, and consists of development of correct attitudes toward the client, and an understanding of the effective influence that the environment of a social setting detoxication facility has on the detoxifying person. The training also includes specific clinical diagnostic information<sup>5</sup> and demonstration to insure that the staff is proficient in triageing the client, that is: determining the nature of the disability, assessing its urgency and making a judgement as to disposition for care. Finally, all members of the house staff, including administration, must earn a certificate for having attended and demonstrated capability in cardio-pulmonary resuscitation. This latter training is provided by the American Heart Association.

The actual process of care of the client begins at the police patrol wagon in which the police transport the client to Haymarket House (see Chart No. 1) after they have determined that his

condition does not warrant taking him to a hospital. Incidentally, this triage function has been done successfully for many years by the policeman who still has to decide whether or not to bring the public inebriate directly to a hospital. At the entrance to Haymarket House the intake person, who is a triage and detoxication technician, assesses the client and determines his suitability for social setting detoxication. If there is any doubt as to an illness or injury which might threaten the health of the client, other than acute intoxication, the client is transported to the back-up hospital for a medical evaluation. Less than 5% (see Chart Nos. 2, 6) of the clients have required this hospital evaluation. At intake a brief history and other data are recorded and the client allowed to recline in a holding area, where the initial stages of detoxication occur. As soon as a client is able to function well enough he is showered, deloused and given clean clothes. He is then moved to another area where he can socialize with other clients and where counselling and group therapy take place. During the period of recovery from acute intoxication the staff member makes frequent checks on the client for any aberration of vital signs which may signal a health or life threatening complication. The philosophy of the clinical staff is that if one is

Chart No. 1						
Incoming Referrals (January-June, 1976)						
	Jan.	Feb.	March	April	May	June
Police Dept.	193	290	470	433	400	355
Cook County Hospital	5	8	4	5	7	2
University of Ill. Hospital	3	3		9	1	4
Total	201	301	474	477	408	361

Chart No. 6						
Emergency Medical Admissions (January-June, 1976)						
	Jan.	Feb.	March	April	May	June
Cook County Hospital	4	5	8	6	7	5
University of Illinois Hospital	3	2	6	6	3	2
Total	7	7	14	12	10	7
% of Total Residents	3.4	2.3	2.9	2.7	2.5	2.0

Chart No. 2								
Discharges (January-June, 1976)								
	Jan.	Feb.	March	April	May	June	Sub-Total	Percentage
Medical Emergency	7	7	14	12	10	7	57	2.6
Refused Referral	105	203	362	334	298	252	1554	70.8
Refused Referral Left Against Advice	6	2	7	10	12	23	60	2.7
Accepted Referral	73	76	82	79	58	69	437	20.0
Work	5	5	8	5	3	5	31	1.4
Home	5	6	6	16	19	3	55	2.5
Total	201	299	479	456	400	359	2194	100.0



Chart No. 3								
Length of Stay (January-June, 1976)								
	Jan.	Feb.	March	April	May	June	Sub-Total	Percentage
Over 5 days	38	12	29	27	19	23	148	6.8
3-5 days	34	28	24	39	40	23	188	8.6
2-4 days	8	20	25	26	24	17	120	5.5
1-2 days	25	19	14	22	11	15	106	4.9
Sub-Total (Over 1 day)	105	79	92	114	94	78	562	25.8
12-24 hours	38	85	162	86	103	70	544	25.0
5-12 hours	26	80	111	141	137	177	672	31.0
1-5 hours	32	47	105	115	66	34	399	18.3
Sub-Total (Under 1 day)	96	212	378	342	306	281	1615	74.2
Total	201	291	470	456	400	359	2177	100.0

in doubt about a client's physical condition, he is to be transported immediately to the back-up hospital for an examination. Those conditions which have accounted for the decision to transport the client for medical care are seizure activity, injuries discovered after admission to the facility, precordial pain, respiratory difficulty, or a history of some severe medical condition such as diabetes or heart disease.<sup>6</sup> The staff also includes a blood pressure test, temperature and a testape urinalysis in the general assessment of the client. Those clients who stay for more than 24 hours are transported to the local Health Department Clinic for a chest X-ray.

After the acute intoxication or withdrawal state is managed, the client is encouraged to stay at the facility for counselling and referral. Sta-

tistically, the majority leave before 12 hours (see Chart No. 3), but of those who stay for a longer period, the referral rate approximates 70%. The number of times clients have been admitted ranges from once to more than twenty times (see Chart No. 4). A referral consists in transporting the client to a recognized rehabilitation center where arrangements have been made for his admission (see Chart No. 5). While awaiting referral, regular A.A. meetings, group therapy sessions, psychodrama, and individual counselling take place.

The six month experience as a demonstration project of Haymarket House has proved a number of things. First, the principle of a social setting detoxication treatment for acute alcoholism is a sound one.<sup>6</sup> Second, the use of drugs is not necessary at this level of acute alcoholism. Third, this class of clients with acute alcoholism shows a different clinical picture than the acute alcoholism sufferer in the private setting. This difference appears to take the form of a greater

Chart No. 4							
Number of Times Admitted (January-June, 1976)							
	Jan.	Feb.	March	April	May	June	
1	156	176	187	162	134	140	
2	31	64	90	69	63	56	
3	10	29	58	52	38	24	
4	3	16	43	43	26	28	
5	1	9	28	31	22	12	
6		4	23	23	26	6	
7		2	15	14	22	13	
8		1	12	14	13	10	
9			7	7	9	14	
10			5	7	5	8	
11			3	7	5	7	
12			2	5	5	7	
13			1	4	4	8	
14				3	8	6	
15				2	6	5	
16				2	4	4	
17				2	5	2	
18					2	3	
19					1	4	
20					1	2	
20+						2	

Chart No. 5							
Outgoing Referrals (January-June, 1976)							
	Jan.	Feb.	March	April	May	June	
Salvation Army	9	9	16	11	6	8	
Cathedral Shelter	11	2	2	1	3		
Christian Ind Lg	11	6	3	7	4	9	
Holy Cross Mission	16	7	7	25	11	12	
C.A.T.C.	7	5	6	7	6	6	
Downey VA, ARP	12	10	11	8	7	11	
Hines VA, ARP	1	10	15	3	4	7	
Read Zone Center	1	5	3	4	7		
1919 W. Taylor	2	4	6	3		2	
Manteno State							
Hospital Program		7		1	1	1	
Elgin State							
Hospital Program		3	4	1			

Chart No. 7								
Race And Nationality (January-June, 1976)								
	Jan.	Feb.	March	April	May	June	Sub-Total	Percentage
Negro	40	63	71	93	98	91	456	20.8
Caucasian	128	189	339	299	246	223	1424	65.0
Spanish Surname	19	19	21	11	20	17	107	4.9
American Indian	14	30	43	44	44	30	205	9.3
Total	201	301	474	447	408	361	2192	100.0
Ages by Decades								
	20's	30's	40's	50's	60's	70's	80's	
	5%	17.3%	32.6%	31%	11%	2.6%	.01%	
Youngest	20 years old							
Oldest	82 years old							

Chart No. 8								
Marital Status (January-June, 1976) Based On New Admissions Only								
	Jan.	Feb.	March	April	May	June	Sub-Total	Percentage
Married	11	8	12	15	10	14	70	7.3
Single	83	90	98	89	49	73	482	50.5
Divorced	51	56	58	33	43	40	281	29.4
Separated	7	13	6	11	15	7	59	6.2
Widower	4	9	13	14	17	6	63	6.6
Total	156	176	187	162	134	140	955	100.0

Chart No. 9							
Veteran Status (Basen On New Admissions Only) (January June, 1976)							
	Jan.	Feb.	March	April	May	June	
Veterans	81	103	124	105	91	96	
Non-Veterans	30	51	43	51	43	44	
No Information	45	22	20	6			
Total	156	176	187	162	134	140	

degree of incapacity on much less alcohol, and in consequence of this lower tolerance and less alcohol intake, a much shorter detoxication time with fewer and less intense symptoms of the acute withdrawal syndrome. A research project dealing with this particular phenomenon is being designed for study at Haymarket House. Fourth, the effectiveness of a social setting detoxication center for this population (see Chart No's. 7, 8, 9) must be judged on its ability to detoxify clients, and not on its ability to rehabilitate, which is an altogether different function not suited to the purpose of a detoxication facility.

Fifth and finally, the Social Setting Detoxication Center, as an effective part of the alcoholism treatment network, acts as an entry point into long term care for an appreciable percentage of perviously "hopeless" and homeless persons. ◀

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# Transport of High Risk Neonates

## Part II: Short Term Intensive Care and Stabilization of the Sick Infant

BY RAJAM S. RAMAMURTHY, M.D., TSU FUH YEH, M.D. AND  
ROSITA S. PILDES, M.D./CHICAGO

*Division of Neonatology, Cook County Hospital, Hektoen Institute for Medical Research, University of Health Sciences/The Chicago Medical School and The Abraham Lincoln School of Medicine of the University of Illinois, College of Medicine, Chicago, Illinois.*

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***This is the second of two parts in a series concerning neonatal care. Part I, which carried clinical and metabolic data from the Cook County Hospital Perinatal Center, was included in the November issue of IMJ.***

In the previous issue of this journal, the clinical and metabolic observations in neonates transported to the Cook County Hospital Perinatal Center in 1974 and 1975 were reported. In this issue, practical suggestions are provided for stabilizing the physical and metabolic environment of the neonate from birth until transferred to an area with an intensive care facility, should this be required. An important aspect of this is anticipation of problems prior to delivery and

adequate preparation to handle them promptly. Table 1 lists conditions which would require the presence of the pediatrician or a person trained in resuscitation of the newborn. Intensive training of the nursery and obstetric nursing personnel in resuscitation is necessary.

It is important to provide the newborn infant with a stable physical and metabolic environment starting from birth. Clear airway, neutral thermal environment, adequate oxygenation, monitoring the acid base status, correction of hypotension and assisted ventilation when required should be carried out in a systematic manner. Table 2 provides a simple mnemonic summarizing the various areas that need the physician's attention.

### *Clear Airway*

Immediately after birth, the mouth and the nose is thoroughly cleared using a bulb syringe or a mucous trap. Use of a suction machine is not required and vigorous suctioning of the pharynx should be avoided, for this can induce laryngeal spasm and bradycardia. When meconium stained amniotic fluid is seen, suctioning is crucial. The mouth, pharynx and nose should be thoroughly suctioned by the obstetrician as soon as the head is delivered—before delivery of the shoulders. Prevention of aspiration of meconium by suctioning before the infant takes its first breath may decrease respiratory morbidity in about 22% of infants who could have developed progressive respiratory difficulties from pneumonitis.<sup>1</sup>



RAJAM S. RAMAMURTHY, M.D., is Assistant Director at the Division of Neonatology of Cook County Hospital Perinatal Center, as well as Assistant Professor of Pediatrics at the University of Health Sciences/Chicago Medical School.

TSU FUH YEH, M.D., is Attending Neonatologist in the Cook County Hospital Perinatal Center, Division of Neonatology, and is also Assistant Professor of Pediatrics at the University of Illinois Abraham Lincoln School of Medicine.

ROSITA S. PILDES, M.D., is the Director of the Division of Neonatology of Cook County Hospital Perinatal Center and a Professor of Pediatrics at the University of Illinois Abraham Lincoln School of Medicine.

**Table 1****Conditions Requiring Vigilance**

1. Previously identified high risk patient
2. Abnormal fetal heart rate patterns or other evidence of fetal distress
3. Meconium stained amniotic fluid
4. Antepartum hemorrhage
5. Multiple pregnancy
6. Preterm delivery

**Table 2****Guide to Stabilization**

- S—Suction  
 T—Temperature  
 A—Atmosphere (oxygen)  
 B—Base deficit  
 L—Low blood pressure  
 E—Endotracheal intubation

*Neutral Thermal Environment*

The fetus in utero has a temperature slightly higher than the mother's core temperature (38°C). Immediately after birth, the baby's body temperature drops due to heat lost principally through evaporation and radiation. The normal infant under cold stress increases heat production in the absence of detectable shivering by catecholamine mediated thermogenesis of brown fat. Oxygen consumption is increased and glucose substrate is quickly depleted. The metabolic response to cold is impaired by hypoxemia, thus adding further problems if the infant is already distressed.

Many different incubators on the market provide a convenient source of heat; the more modern radiant warmers are preferred because they allow easy access to the infant while certain procedures are being done. The servo control mechanism in these radiant warmers regulates the heat output depending on the infant's skin temperature. Infants in incubators may continue to lose heat by radiation if the room temperature outside the incubator is low. A simple plexiglass shield placed over the infant prevents this heat loss. The environmental temperature required to keep the body temperature at 36.5-37.5°C with minimal metabolic effort depends on body weight and postnatal age. Standard charts are available for easy reference.<sup>2</sup> Rapid heating and overheating may lead to apnea, convulsion and increased metabolism. Gradual warming over a 20 to 30 minute period and maintenance of temperature at all times is necessary to avoid rapid fluctuations in metabolism.

*Oxygenation*

It is learned that limiting the use of ambient oxygen to no more than 40% for fear of retrolental fibroplasia is often bought at the bitter cost of unnecessary deaths and brain damage.<sup>3</sup>

Inspired oxygen concentration (Fi O<sub>2</sub>) of 60-100% may be required for resuscitation of the

depressed neonate. Attention must be paid to the type of bag used for resuscitation as many of them provide only 40%-60% oxygen. When oxygen is administered, the Fi O<sub>2</sub> must be monitored. If the infant is cyanotic, oxygen concentration may be raised to 100%. When cyanosis is no longer visible, Fi O<sub>2</sub> may be reduced by 10% at 20 minute intervals as long as arterial pO<sub>2</sub> is > 80 mm Hg. If blood gases are not available, oxygen concentration should be reduced at similar intervals, using the infant's color for guidance. The concentration required would be about 10% higher than the level at which cyanosis is seen.

Oxygen, even when administered for a short period, should be both warmed and humidified. If cold air is blown on the infant's face, eg., when placed in an oxygen hood, body temperature drops since the trigeminal area of the face is most sensitive to cold. Temperature of the inspired air should be at the body temperature or thermoneutral environment depending on whether the infant is intubated or not.

*Correction of Acidosis*

The one minute Apgar Score correlates well with the fetal scalp pH at the time of birth, the pH usually being lower than 7.25 when the Apgar is below 4.<sup>4</sup> In a severely asphyxiated infant, sodium bicarbonate may be required at resuscitation even before the acid base status is known. In an emergency, drugs may be administered via the umbilical vein through a catheter inserted up to 8-10 cm. Under more controlled circumstances, the umbilical artery is the preferred route as this also provides a source for arterial blood sampling. When the base deficit is not known, 3 mEq/kg of sodium bicarbonate diluted with equal amounts of water is infused over a 5-10 minute period. When the base deficit is known, actual requirements may be calculated using the formula: total base deficit x weight in kg x 0.3 mEq. Half the requirement is given at the beginning. Bicarbonate should not be administered unless adequate ventilation is established.



### *Hypotension*

Hypovolemia and shock is suspected when there is history of maternal bleeding, fetal asphyxia, pallor, poor filling of the blanched skin and, not infrequently, inability to establish spontaneous respiration at resuscitation. Blood pressure measurements are important and may be done by the cuff method using a doppler or a transducer in an indwelling umbilical artery catheter which gives a more accurate reading of blood pressure. Normal blood pressure range for infants of different weight categories is available.<sup>5</sup> When shock is present, treatment is urgent. Blood volume expansion may be done using isotonic saline, 5% albumin, plasma or blood. Ten to twenty ml/kg of any of the above may be given over 2-3 minutes, and the response noted.

A 10% glucose infusion with or without bicarbonate must be started on all sick infants. A stressed neonate is rapidly utilizing glucose; also, a running intravenous line may be used for administration of drugs in an emergency. Blood sugar determination is necessary to detect both hypo- and hyperglycemia. About 42% of the very small sick premature infants develop hyperglycemia in the range of 152-875 mg/100 ml with infusion of 10% dextrose.<sup>6</sup> In these same infants there is also a high incidence of ventricular and cerebral hemorrhage. Although the direct cause and effect relationship is not established, it is suggested that the blood sugar of neonates be kept in the range of 50-120 mg/100 ml. Lower concentrations of dextrose infusion may be required in the very sick premature infant.

### *Ventilation*

Adequate ventilation may be carried out by mask and bag breathing. A small infant mask is placed covering the nose and mouth of the infant. The neck is slightly extended and bagging is done at the rate of 40-60 per minute. Rise and fall of the thorax with each breath assures good ventilation. If the infant is properly resuscitated, the heart rate comes up first, followed by the blood pressure. The infant then becomes pink and lastly spontaneous breathing is established. If diaphragmatic hernia is suspected, bag breathing should be avoided and the baby should be intubated instead.

Infants born with Apgar Scores 0-3 require endotracheal intubation. It is done under direct vision using a laryngoscope with an infant blade (size '0' or '1'). The polyvinyl endotracheal

tubes, size 2.5 to 3.5, are suitable for most infants. The ease with which endotracheal intubation is achieved comes with practice. Intubation may be practiced on infant models or on still born fetuses. The tube is placed one centimeter past the vocal cord; adequate ventilation of both lungs is checked by auscultation and the position of the tube is confirmed on X-ray.

### *External Cardiac Massage*

If no heart tones are heard or if the heart rate is less than 60 per minute, external cardiac massage is begun. The heart is more in the midline in newborn babies. With the thumbs placed on the sternum and the fingers at the back, compression of the sternum about 2-3 cm will provide adequate compression of the heart to maintain circulation. The ratio of cardiac massages to ventilation is 3:1. The femoral or carotid pulses must be felt during external cardiac massage. Administration of intracardiac epinephrine 0.1cc (1:10,000 dilution) may be necessary.

### *Pneumothorax*

Vigorous resuscitation may be complicated by occurrence of pneumothorax. Occurrence of apnea, cyanosis, shifting of apical impulse, absence of breath sounds, tympanic note on percussion of chest, or sudden deterioration of condition of the infant who was responding well to resuscitation, may all be indicative of tension pneumothorax. A 20-30 ml syringe and 18 gauge needle inserted for 1/2 cm in the anterior axillary line on the side pneumothorax is suspected would be a life saving procedure. Immediate X-ray and surgical help for insertion of chest tube should follow.

### *Narcotic Antagonist*

The use of narcotic antagonists should be reserved only for depressed infants whose mothers have received narcotics within 4-6 hours of delivery or infants of addicts when the time of drug intake is not known. In this regard, Naloxone hydrochloride (neonatal preparation) 0.01 mg per kg is the preferred drug. Naloxone hydrochloride does not cause depression in itself and repeated doses may be given safely. When antidotes are administered to infants of addicts, acute withdrawal symptoms may be provoked, hence these infants should be monitored carefully.

## Monitoring

Maintenance of all parameters discussed is of utmost importance. Heart rate and respiratory monitors have become an integral part of caring for the sick infant. This provides continuous monitoring and does not tie up the time of nursing personnel. Temperature monitoring is done by the servo control mechanism present in most modern isolettes and radiant warmers.

## Parent Infant Relationship

The mother and father should be allowed to see and touch the infant as much as possible without compromising his physical environment. This should be done in every case prior to transport of the infant to another facility. The initial maternal infant contact is considered essential for the psychological well being of the parents and the infant.

## Conclusion

Resuscitation, stabilization and intensive care when required should be a continuum of smooth

transition from one phase to the other. The investment made in providing optimum care in the first few minutes and hours of life would assure quality survival and a chance for every baby to grow to its full potential. ◀

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## Viewbox

(Continued from page 578)

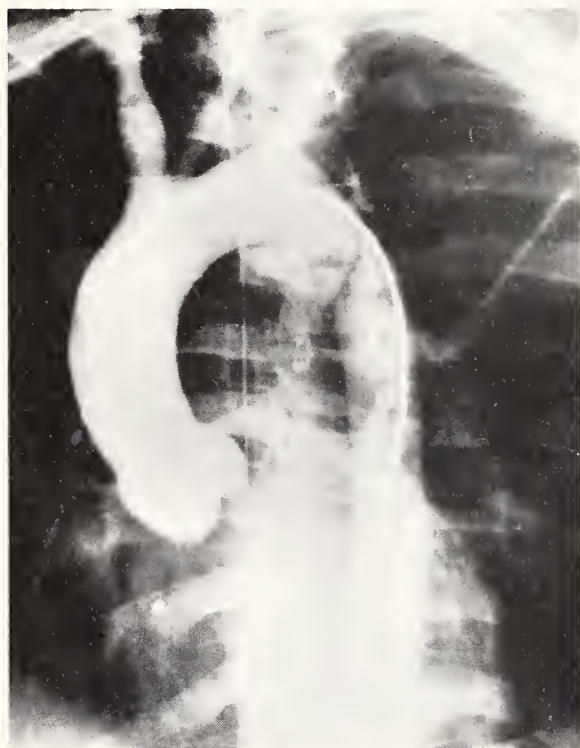


Figure 3

**DIAGNOSIS:** *Traumatic rupture of the aorta at the level of the isthmus.* At the time of the chest examination there was an attempt at the use of a C.V.P. catheter which clouded the findings on the chest film. However, the arrow on Figure 1 points to a collection of fluid which is extrapleural and compressed the apex of the left lung downward. In addition there is a deviation of the trachea and nasogastric tube to the right. Combined with widening of the mediastinum this was highly suggestive of a traumatic rupture of the aorta. Even though the loss of blood could be explained on the basis of the known ruptured spleen, it was felt that the patient required an emergency aortogram. This was done and demonstrated the classic transection of the aorta at the level of the isthmus which occurs in about 65% of cases of traumatic rupture. The importance of the PA chest findings is stressed as they may be the initial clue that a more serious injury is present.

In summary the findings that should suggest this are:

1. Widening of the mediastinum.
2. An extrapleural collection of blood around the apex of the left lung.
3. Deviation of the trachea and esophagus by the mediastinal hematoma.
4. A downward displacement of the left main stem bronchus by the mediastinal hematoma.



# Doctor's News

**MENTAL HEALTH BENEFITS**—The Illinois General Assembly recently sustained Governor Walker's amendments to H.B. 1080.

As passed by the General Assembly in June, 1976, H.B. 1080 would have required all Illinois insurance carriers to offer optional mental health benefits up to the same limits offered for other medical/surgical coverage, both inpatient and outpatient. The original bill also provided for the independent reimbursement of all registered psychologists, whether or not they were clinically trained.

Both ISMS and the Illinois Psychiatric Society (IPS) objected vigorously to the legislation, contending that it would result in a serious diminution of mental health services. The bill subsequently was amended by Governor Walker to restrict payments to fully licensed physicians and clinical psychologists and to require insurance carriers to offer optional mental health benefits to group policyholders only. The governor also added a co-insurance provision permitting insurance carriers to require a 50% co-insurance payment with a maximum payment of the lesser of \$10,000 per year or 25% of the lifetime policy limit.

Expressing concern about the lack of medical review of such cases, ISMS and IPS continued their opposition to the amended version and unsuccessfully worked for its defeat during the current "veto session" of the General Assembly. Both organizations also expressed concern about the propriety of assigning the determination of a "clinical psychologist" to the Department of Insurance. Illinois currently has no statutes defining the activities of "clinical psychologists."

**CANCER INFORMATION TELEPHONE-TAPE SYSTEM**—The Illinois Cancer Council Comprehensive Cancer Program has instituted a Dial-Access System for Illinois physicians. Over 200 tapes with the latest diagnostic and therapeutic information for specific neoplastic disease problems can be selected by telephoning and requesting by number any topic listed in the catalog. Catalog requests and further information about the program may be obtained by writing the Communications Dept., Illinois Council, 37 S. Wabash, Suite 507, Chicago, Illinois 60603; or by telephone, 800-972-0586 (toll free in Illinois).

**MALPRACTICE INSURANCE NOTES**—The Illinois State Medical Inter-Insurance Exchange has issued a reminder that peer review committees are engaged in evaluative studies of potential liability in order to ensure the stability of the insurance program. Physicians may be requested to provide information to these committees at any time. Committee decisions may eventually bring surcharges, restriction of insured procedures or, in extreme situations, cancellation of coverage.

ISMIS has also warned physicians to scrutinize offers such as that being made by a Chicago insurance broker, proposing \$5 million of excess malpractice coverage for about \$130 annually. The policy actually provides only excess personal liability for premises, autos, etc. The broker does have limited facilities for primary and excess malpractice protection through out-of-state carriers offering claims-made policies, at substantial rates.

**NEW PARKINSON'S DISEASE CENTER**—The American Parkinson Disease Association has opened an information center on the campus of the Northwestern University Medical School. The APDA center will maintain a current library of treatment-related literature, equipment and physical therapy services, in addition to a listing of physicians interested in the treatment of Parkinson's Disease. Further information may be obtained by writing the Parkinson Disease Information Center, 303 E. Superior Street, Room 11-465, Chicago, 60611, or calling (312) 649-8989.

**LUNG DISEASE DATA**—Respiratory infection, produced most often by air pollution, smoking and work-related pollutants, is the largest cause of time lost from work or school in the United States, according to statistics released by the Chicago Lung Association. Further information regarding lung disease is available from the Chicago Lung Association, 312-243-2000. This year marks the seventieth anniversary of Chicago Lung Association service and research for the prevention of lung disease in Chicago and Cook County.

**PHYSICIANS IN THE NEWS**—Illinois physicians holding new elective posts include **Dr. Robert B. Rowe**, Urbana urologist, president of the American Group Practice Association; **Dr. Frank R. Hendrickson**, Chicago, president of the American Society of Therapeutic Radiologists; **Dr. Charles Schlageter**, secretary of the Chicago Medical Society; and **Dr. Hugh Rohrer**, Peoria, first vice chairperson of the Statewide Health Coordinating Council. Dr. Rohrer is director of the Peoria Public Health Department and president of the Illinois Association of Public Health Administrators.

**Richard C. Shaw, M.D.**, has been appointed vice president and medical director of the Chicago-based Blue Cross and Blue Shield Plan. Dr. Shaw concluded his private practice in internal medicine to join Connecticut Mutual Life Insurance Company in 1961. He has served as the firm's medical director since 1970. The new Acting Head for the University of Illinois Department of Medicine at both the UI Hospital and Abraham Lincoln School of Medicine is **Dr. Donald E. Wilson** of Chicago. **Dr. Emerson Day** has been chosen to serve as Associate Director of Cancer Diagnosis and Detection at the Northwestern University Cancer Center, and will also serve as attending physician at Northwestern Memorial Hospital and professor of medicine at Northwestern University Medical School.

Five Illinois physicians were recently admitted as fellows of the American College of Physicians. **Richard L. Byyny** and **Ennio C. Rossi**, of Chicago, **Yi-Hsiang Chen** of Glenview, **Ewald T. Sorenson** of Rockford and **James L. Rosenberg** of Winnetka were among 275 new fellows elected at the November meeting of the College's Board of Regents.

Other new appointments include **Dr. Erich E. Brueschke** as chairman of the Rush-Presbyterian-St. Luke's Hospital department of family practice, **Dr. William Schumer** as Chief of Surgical Services at the Veterans Administration Hospital in North Chicago, Illinois, **Dr. Cullen Schwemer**, as Director of Psychiatry at Good Samaritan Hospital in Downers Grove, and **Dr. Leon R. Kass** as the first Henry R. Luce Professor in the Liberal Arts of Human Biology at the University of Chicago. Dr. Kass' position has been designed to promote a broadening of health education and will include instruction in courses concerning the philosophy of biology and medicine and their role in the social structure. The American Academy of Ophthalmology and Otolaryngology has announced the election of **Dr. Eugene L. Derlacki**, Chicago, as its new president.



## Self Regulation versus Government Intervention



In order to avoid unnecessary restriction and harassment, physicians tend to resist any law bearing on medical practice. Ignoring content as well as intent, we oppose the regulations and justify our opposition by categorizing all legislation as "another example of the bureaucracy's attempt to take over health care." And, indeed, our concern is real.

Blind opposition without regard for public feeling about new regulations, however, is self-defeating. Our anti-regulatory arguments fall flat in the face of disclosures of gouging on laboratory tests, public aid cheating, and allegations of unethical or illegal conduct on the part of what we know to be only a very few doctors.

Opposing all regulations gives the impression that we seek to protect a tiny minority of cheats. We therefore appear to be willing to sacrifice the good of the public to the preservation of the medical profession from government domination, (although this is not truly the case). Unless we ourselves can find a means of purging the swindlers from our profession, we will be forced to accept restrictions which are both a nuisance and a necessity.

*Joseph H. Skom, M.D.*

Joseph H. Skom, M.D.

# MEN OF MEDICINE, 1776-1976

## Health Care in Illinois *Circa* \*1776

BY EMMET F. PEARSON, M.D./SPRINGFIELD

*Dr. Pearson is Clinical Professor of the History of Medicine, Southern Illinois University School of Medicine, Springfield*

During the last half of the 18th century Illinois country was a notorious sickbed. Disease was rampant among native Indians as well as French, Spanish, British and American explorers, religious zealots, soldiers, trappers, merchants and settlers. During those fifty years, Illinois emerged as a geographic entity. However, disease and death depleted the native population and discouraged people of European origin from immigrating and exploiting the land.

Although warfare continued between Indian tribes, between Indians and Europeans and between Europeans of different national identities, no large pitched battles occurred and direct combat did not account for substantial casualties. Instead, small pox, malaria, measles, dysenteries, tuberculosis and other infectious diseases became the mortal enemies of all competitors for supremacy in Illinois.

Each ethnic group or national alliance had its own doctors and health care systems. While folk remedies often proved satisfactory for trauma, midwifery and simple ills, none could cope with deadly epidemics and endemics, most of which had been imported from the Old World.

The Indians were not the ignorant savages so commonly depicted. Their philosophy and lifestyle were vastly different from that of the Europeans, but they possessed certain intuitive capabilities often incomprehensible to the invaders. The Indian medicine man used common sense, physical methods, hereditary knowledge of herbs and some magic giving him a power second only to that of the tribal chief. The medicine man's methods were surprisingly similar to those used by European doctors. Both groups practiced blood letting and purging, induced sweating and vomiting and applied herbs internally and externally.

One herb used by the Indians, ginseng, has been used by the same name and for the same problems by the ancient Mongolians, exploring French, pioneering Americans and modern Chinese. Some early Jesuit priests collected ginseng as a cash crop which was exported from America to China via Europe and Africa. The ginseng story is a thread that pulls together thousands of years of medical history. This herb is now having a strong revival as a panacea in Europe and in the United States.



Before they had much contact with the French, the native Illinoisians were quite healthy and some were said to have lived 100 years. However, they did suffer arthritis, bronchitis, pneumonia, skin infections, diarrheal diseases and possibly syphilis. Digestive disorders often resulted from periods of starvation which alternated with periods of overeating. Some children had rickets. But Illinois Indians did not suffer from the scurvy common to northern tribes. Obesity, insanity and alcoholism were rare or nonexistent. Traditional stoics, they were trained to ignore pain. The Indians traded a few diseases to the Europeans such as dysenteries, worms and skin infections, but they certainly got the worst of the trade by contracting small pox, malaria, measles, gonorrhea and cholera. By the year 1776, hardly any tribe in Illinois had the strength to put up a good fight.

### **Early French Influence**

The first French explorers in the Illinois and Mississippi Valleys were usually accompanied by surgeons. A 17th century surgeon bled Father Marquette as he lay ill with "bloody flux" near what is now Chicago. Surgeons Louis Moreau and Jean Michael accompanied the great Mississippi River expeditions of LaSalle.

The Jesuit priests and their rivals, the Fathers of the Seminary of Foreign Missions, came to Illinois from Canada at about the same time and made the first intimate contact with several tribes. At great sacrifice and frequent martyrdom they attempted the conversion of the "savages" to Christianity. There were priests in both orders that had some medical training, and their efforts in health care were secondary only to their religious mission.

One legend tells of a Father James Gravier at a mission near Peoria, who sent a request to Kaskaskia for alum, vitriol, anise seed and other medicants. This martyred priest was pierced by arrows shot by an angered Indian and died after months of great suffering.

The early French colonists in Illinois along the Illinois and Mississippi rivers emigrated from Canada. A few prosperous bourgeois merchants and their elite ladies lived in style, but the common Frenchman usually cohabited with Indian squaws, which brought many half-breeds. The French kept both Indian and African slaves although the Africans were the more resistant to Old World diseases such as small pox and malaria.

The Illinois French subsisted mostly on hunting, trapping and trading with the Indians and did not develop a large-scale agricultural society. They did a little farming near their villages in the American Bottom, some of the most fertile land on earth. Corn was raised in some plots, and the Jesuits imported wheat grain seed from Vera Cruz. There were horned cattle, domestic fowl and plenty of wild game. They did not suffer from food deprivation.

By 1750, the French tenuously held the entire heartlands of North America with a chain of military posts, forts and small scattered settlements stretching from Quebec to New Orleans with the greatest concentration in Illinois. The strongest fort in North America was built at Ft. de Chartres on the Mississippi River in what is now Randolph County, Illinois, and had the only hospital between the Gulf of Mexico and the St. Lawrence. Measuring 93 by 18 feet, the hospital was built with pickets, covered with straw, and plastered. There was a double chimney. A chief surgeon at Ft. de Chartres hospital was Pierre Ignace de la Ferne and one of his assistants was Andre Conde, his son-in-law. There were French civilian settlements at nearby Kaskaskia, Prairie du Rocher, St. Phillippe and Cahokia, as well as at Peoria.

Many French preferred the Indian medicines to those of their countrymen, and conversely many Indians preferred the medicines of the priests and other French physicians. A jealous rivalry between the French physicians and the Indian medicine men sometimes resulted. Pestilences in tribes often appeared to follow the arrival of priests or other Frenchmen.

Although heading for ultimate bankruptcy and revolution, the people in France enjoyed a great period of enlightenment during the 1750's under King Louis XV. Medical education was encouraged. Knowledge of anatomy and physiology supplanted metaphysical and philosophical explanations for disease. No longer were infectious diseases necessarily considered acts of God. The presence of living, communicable "animiculae" was postulated. Surgery was given a big impetus after a surgeon cured King Louis XIV of rectal fistula.

Some of the well educated French doctors came to Quebec and to New Orleans where hospitals were built and operated by nuns. Some medical training was performed in the hospital wards, but the only North American medical school at that time was in Mexico City. A Madame Belieu trained in the Hotel Dieu in Quebec and came

to Kaskaskia to be the first woman doctor in Illinois. She was appointed "Director of Morals and Medical Matters."

The French in Illinois did not suffer from major epidemics until about 1750. As more contacts with New Orleans developed, more subtropical disease came north. Each summer malaria attacked nearly the entire military and civilian population and became the chief debilitating factor and deterrent to immigration for the next 100 years. The curative powers of Peruvian bark or Jesuits bark (which contain quinine), had been recognized for over a century, but no supply was available in Illinois during the 1700's.

As lack of support and supplies from Quebec or New Orleans caused the French strength to dwindle, the Spanish who controlled the land to the West of the Mississippi River sent forays into Illinois in an attempt to gain a foothold. The Spanish militia had few surgeons and depended mostly on the French physicians and Indian medicine men for health care. One Spaniard sent word to Seville to send no more doctors because the Indians were better healers. Although they claimed exclusive navigation rights to the Mississippi River, the Spanish did not have the military strength to enforce that order. The French, and later the Americans, used the river despite Spanish protests.

At the time of the British-French struggles for North America, it was said that the British doctors were devoted to toxic medicine and copious bleedings, whereas the more philosophical French were therapeutic skeptics and depended on physical measures, diet and moral support.

The French were forced to surrender their claims to Illinois country to the British in 1763 after defeat in the French and Indian wars. Many French crossed the river into Missouri which was called "Spanish Louisiana" or sometimes "Spanish Illinois."

### **British and American Control**

The British arrived in 1765, and encouraged the remaining French settlers and doctors in Illinois to continue their courts, government and medical practice. Dr. Andre Conde, surgeon of Ft. de Chartres, joined the emigration into Spanish Louisiana, but Dr. Jean Laffont remained in Illinois and sympathized with news of the growing Colonial rebellion on the East Coast.

Surgeons accompanied the British military into Illinois and a civilian doctor named William

Annesley was appointed by the Crown to study the health of the neighboring Indians and determine what could be done to prevent their extinction. Conversely, another English officer was said to have "generously" donated blankets freshly used by smallpox patients to the Indians to start an epidemic and decrease their number.

The British position in Illinois was never strong, and the capitol at Kaskaskia capitulated to the daring General George Rogers Clark and his Virginians in 1778 during the Revolutionary War. Clark claimed the territory for Virginia. Patrick Henry, Governor of Virginia, sent congratulations to the French doctor, Laffont, whom Clark had sent to convert the French at Vincennes to the American cause. Largely due to the French physician's efforts, General Clark captured that Wabash River settlement handily and the Americans promptly established religious freedom, political equality and economic security for the French in Illinois.

This small company of Americans under Clark who founded a base on the Mississippi River not only secured the mid-continent for the Americans, but also laid the foundation for the Louisiana Purchase and the winning of the West a few years later.

As the 18th Century came to an end, Americans from the woods of Kentucky trickled slowly into the Illinois French villages. The total European population in Illinois in 1800 was probably less than 3,000, whereas there had been many more than that number of Frenchmen in 1750. The more aggressive Americans soon became the owners of land and shops.

Some American doctors were among the new immigrants. A Dr. George Fisher came to Kaskaskia and introduced vaccination against smallpox. The daybook of Dr. Enoch Paine, who came to Kaskaskia at the turn of the century, is available in the Chicago Historical Library. The entries show that he operated a lodging house and tavern while practicing medicine. He intermingled charges for medicines, house calls, vaccination and deliveries with sales of whiskey, gin, egg nog, feed for horses and a night's lodging. His medicines included cathartics, emetics, vermifuges, mercury and various herbs, but there is no indication that he performed bleedings. Some of the early doctors used calomel, other forms of mercury and antimony. Sulphur also had its advocates and laudanum (opium) may have been used.



Virginia relinquished its claim on Illinois in 1784. Three years later the Northwest Territory Resolution was enacted by Congress. This Act constituted one of the great democratic documents in history, guaranteeing freedom of self-development, freedom of enterprise and freedom from involuntary servitude. The Resolution enabled Illinois to become a separate territory, and later a slave-free state.

Early French doctors living in St. Louis were said to have extended their practice into Illinois. Among those were Jean Valteau, Antoine Reynal, Bernard Gilkus, Claude Mercier and Andre Conde (whose library included 78 volumes in surgery). A famous French doctor, Antoine Saugrin, came from Paris through Illinois territory about 1790. He was a learned and inquisitive man, a botanist, naturalist, philosopher and wise physician. He gave free small pox vaccinations to the poor. After the Louisiana Purchase, Dr. Saugrin is said to have supplied the Lewis and Clark expedition with medicine, thermometers, barometers and matches.

Environmental improvements led to the rapid settlement of Illinois in the early years of the 19th Century. General sanitation, better water and food supply, improved lifestyle and better control of malaria, small pox and dysenteries contributed to Illinois' transition from a place to be feared to a land of opportunity and good health.

In the year 1976 it is appropriate not only to pay homage to embattled farmers who fired shots "heard 'round the world" and to patriots who laid the foundations for the American dream, but also to the memory of the laymen, women and doctors of all ethnic groups who struggled with life and death in Illinois country two hundred years ago. ◀

*Edited by Gerry Schermerhorn*

#### References

A complete bibliography for "Health Care in Illinois Circa 1776" may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, 60603.

## EKG

*(Continued from page 568)*

**Answers: 1. E 2. E**

The tracing shows prolonged QT interval with tall T waves. The electrocardiographic changes are suggestive of a cerebrovascular accident. A CVA may produce deeply inverted T waves or tall positive T waves like those seen in this patient. They are most prominent in the mid to lateral precordial leads. Reciprocal T wave inversions are not seen. The duration of the tall CVA T waves is variable. The etiology of both the tall and the deeply inverted T waves seen in CVA is not clear. Yanowitz *et. al.* suggested one cause as being the imbalance of sympathetic activity (*Circ. Res.* 18:416, 1966) by showing that stimulation of the left stellate ganglion in dogs produced increase in T wave positivity, while stimulation of right stellate ganglion resulted in T wave negativity. QT prolongation occurred in both cases. The patient expired. At autopsy there was no evidence of heart disease but subarachnoid hemorrhage was found.

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# *1918 Pandemic Influenza and Pneumonia In a Large Civil Hospital\**

JOHN W. NUZUM, M.D.; ISADORE PILOT, M.D.; F. H. STANGL, M.D., AND  
B. E. BONAR, M.D./CHICAGO

Submitted by Isadore Pilot, M.D., Chicago

The following report was first printed in the November 9, 1918, issue of JAMA. It represents one of the earliest comprehensive and authoritative studies of the 1918 influenza pandemic in Chicago.

Following the reports of a rapidly spreading and highly fatal pandemic of influenza and pneumonia in the Eastern States, and while the epidemic of influenza was raging at the Great Lakes Naval Training Station, a severe outbreak of this disease appeared among the civil population of Chicago. During the past five weeks, from September 23 to October 29, more than 2,000 patients were admitted to the wards of Cook County Hospital. Of these, 642 died, a mortality of 31 per cent. It will be noted that of the first 500 deaths, the age period of highest mortality falls between 25 and 30 years.

Among the total number of admissions during this period there were 122 soldiers, and thus far twenty-one cases have terminated fatally—a mortality of 16 percent. So far as the admissions to a large charity institution, such as the Cook County Hospital, may be regarded as an index to the prevalence of the recent epidemic in Chicago, it appears that the disease is now definitely on the decline. Accordingly, it seems pertinent to report the results of an intensive study conducted during the past five weeks in the morgue and the laboratory of the Cook County Hospital.

## **Clinical Picture**

The incubation period varied from a few hours to one or two days. Shortly after the arrival of the first fifty soldiers, five of the nurses in attendance on these patients became violently ill, and during the following two weeks more than

fifty nurses and twelve of the resident physicians contracted the disease. Three of the nurses died. Blood cultures, nasopharyngeal and tonsil swabs and cultures of the washed bronchial secretions were immediately taken by the laboratory staff, and four of the laboratory assistants were suddenly taken ill within the next forty-eight hours.

The onset is sudden, with complaint of severe headache, dull, aching pains in the muscles and joints, general weakness and quite commonly dull pains in the lumbar region. Conjunctivitis is not infrequent in the initial stages. Sore throat is unusual. The patient takes to bed with chilly sensations, and the fever rises rapidly from 101 to 104 F. Early prostration is the rule. Epistaxis occurs in a considerable number of patients, in one person as much as a pint of bright red blood gushing from the nostrils. The pulse is accelerated and the respirations vary from 20 to 36 a minute. The second to the fourth day marks the critical period for the average patient. Remissions may occur, but among our cases more frequently following the crisis the temperature rises rapidly again and a slight bronchial cough develops, productive of small amounts of thick yellow or yellowish brown sputum teeming with gram-positive encapsulated pneumococci. There can be no doubt that the bronchial secretions are highly infectious at this time and that the disease is transmitted by personal contact and by droplet infection occasioned by coughing and sneezing.

Moreover, very early after the onset, careful physical examination of the patient's chest will often reveal scattered rales with areas of consolidation over the lower lobes and especially the right lower lobe. The bronchopneumonic process begins as an intense acute hemorrhagic tracheobronchitis, rapidly extending to the finer bronchioles of the lung. In the acute fulminating

\*From the Laboratory of Pathology of the Cook County Hospital.



cases the patients become markedly cyanosed, and death results from an asphyxiative bronchiolitis with large quantities of frothy blood-tinged fluid exuding from the mouth and nostrils.

In the more protracted cases, particularly in civilian patients, the bronchopneumonia extends gradually to the left lower, and right middle and upper lobes, and clinical evidence of a severe toxemia manifests itself. Blood counts taken early after the onset of the initial symptoms exhibit a striking leukopenia as low as 1,800 per cubic millimeter and averaging from 3,000 to 4,000 per cubic millimeter. With the onset of the pneumonia a definite leukocytosis quite commonly appears. The urine shows traces of albumin with hyaline and granular casts. Blood cultures taken early and late in the course of the disease and inoculated into glucose broth and plated in blood agar have remained uniformly sterile in forty-two instances.

### Morbid Anatomy

Of the first forty postmortem examinations made on the bodies of persons dying both early and late of bronchopneumonia, it was possible to obtain cultures from the nasopharynx, tonsils, washed selected bronchial sputum and from the lung parenchyma. Cultures were also obtained from these sites before death. The first eight necropsies were all of acute fulminating cases in young soldiers of excellent muscular development and physique. The course of the disease ranged from three to five days. Death was preceded by marked cyanosis and clinical evidence of acute asphyxiative bronchiolitis.

At necropsy the pleural cavities contained blood-tinged fluids remarkably free from fibrin content and varying from 300 to 1,000 c.c. in amount. The pleura of the lungs was fibrin free and regularly the seat of petechial and confluent hemorrhages. On cutting transversely across the trachea to reflect the viscera from the thoracic cavity, large quantities of blood-tinged, frothy fluid exuded from the air passages. The lining of the trachea and main bronchi presented a deep purplish red, and this intense inflammatory condition extended downward into the finest bronchioles. The consolidation was always lobular in type and involved most frequently the lower lobes, less often the entire middle and lower half of the right upper lobes. Marginal compensatory emphysema presented itself with striking regularity. The peribronchial lymph glands were acutely swollen and edematous. Cut surfaces of the lung presented a mottled, firm, granular ap-

pearance with intervening areas of dark red aerated lung tissue. Large quantities of bloody serum bathed the smooth, fibrin-free cut surfaces of the lung. The right heart was acutely dilated, in two instances the tricuspid valve ring measuring 13 and 14 cm., respectively, from cut edge to cut edge. In another body, bilateral symmetrical hemorrhage of rather huge dimensions was present in the tissues of the fatty capsules of both kidneys. The liver and kidneys were heavier than normal and the seat of fatty changes and parenchymatous degeneration. Passive hyperemia of the pia-arachnoidal vessels over the cerebral cortex, and edema of the leptomeninges were not uncommon. We desire to emphasize the fact that the amount of consolidated lung parenchyma was small as compared to the pneumonic consolidation quite regularly present in the more protracted cases among civilians. It will be noted that *B. influenzae* was isolated from only three of the lungs at necropsy in these eight early cases, in one instance in particularly pure culture.

In the more protracted cases among civilians the bronchopneumonic process presents a rather uniform bluish gray hue with the cut surface bathed in grayish yellow pus—a massive, confluent, pseudolobar pneumonia. Fibrin is frequently present over the pleura of the lower lobes of the lungs. In only one case was an empyema present. The hemolytic streptococcus was isolated in pure culture and identified in direct smears from the pus.

### Bacteriologic Findings

A careful detailed bacteriologic study of the prevailing epidemic, especially among the civilian population, forms the basis of this paper. Bacteriologic reports of the pandemic in Europe show that the influenza bacillus was found only exceptionally while pneumococci, streptococci and *Micrococcus catarrhalis* were recovered with considerable regularity from the sputum, nose and throat cultures. In Germany a circular letter addressed to the leading bacteriologists requesting the results of their laboratory investigations brought forth the following replies<sup>1</sup>: "Pfeiffer had not examined a sufficient number of cases at Breslau, but found his bacillus in some while failing to recover it from others, and was still investigating the causes of this discrepancy." Gruber in Munich and Friedmann in Berlin failed to find the influenza bacillus, and report streptococci and pneumococci as the common agents of the complicating pneumonias. Kolle in

Frankfort failed to find *B. influenzae* in any of the cases which he had thoroughly examined.

Among the English observers, Gotch and Wittingham<sup>2</sup> isolated *Micrococcus catarrhalis*, with which they claim to have produced the disease in man. Little, Garofalo and Williams<sup>3</sup> found a gram-positive coccus which they believe to be the etiologic agent of the disease. From the Eastern States Keegan<sup>4</sup> in Massachusetts and Park<sup>5</sup> in New York have isolated the influenza bacillus in a high percentage of cases. These reports concern soldiers and sailors chiefly. Our study was made principally of the civilian population.

During the present epidemic in Chicago, more than 3,000 blood agar plate cultures have been made from swabs of the nasopharynx, tonsils and washed selected bronchial sputum and from the viscera and body fluids at necropsy in search for the influenza bacillus or other micro-organisms of possible etiologic significance. Blood agar plate cultures were made from the swabs of the nasopharynx and tonsils in more than 100 patients approximately equally divided into early and late cases. The washed bronchial secretions from the same patients were both plated and streaked on the surface of blood agar plates. Control cultures from the nose and throats of normal individuals were also made. In both groups a peculiar gram-positive coccus growing in grayish white colonies and exhibiting marked pleomorphism in stained smears was present with considerable frequency. The smaller coccal bodies passed Mandler filters in two instances. This coccus was nonpathogenic both for man and the ordinary laboratory animals.

The percentage incidence of the various organisms isolated from the nose, throat and sputum of 100 patients has been determined. The influenza bacillus was recovered in four cases from the washed sputum—in three instances in predominating cultures, but always in symbiosis with staphylococci. It was not present in the nose or throat swabs. The predominating organism was the pneumococcus isolated from the washed sputum in 70 percent, and from the throat in 74 percent of the cases. *Streptococcus hemolyticus* occurred in the washed sputum in 20 per cent, or twenty patients.

To determine how early and with what frequency the various bacteria invade the lungs, a series of lung punctures was made both before and after clinical evidence of pneumonia presented itself. A sterile needle attached to a glass syringe was passed through the intercostal spaces into the lung parenchyma, and lung tissue plus

serum was aspirated sufficient to streak the surfaces of blood agar plates at the bedside. In addition, some of the aspirated material was inoculated into poured blood agar plates in each instance. Of thirty-six consecutive lung punctures taken during life, twenty-one were sterile. The pneumococcus was present in pure culture in 72.6 percent; hemolytic streptococcus in 19.8 per cent, and *Micrococcus catarrhalis* in 6.6 per cent.

The findings in cultures of the lung tissue streaked and plated on blood agar at necropsy showed *B. influenzae* was isolated in three cases, or 8.7 per cent, in one instance in practically pure culture from both lungs. Again the predominating organism was the pneumococcus, occurring in 75 per cent of the lungs at necropsy, from ten cases in pure culture, eleven times in predominating culture and in five instances in mixed culture. Of the various types of pneumococci recovered, Type II was present in 30.5 percent of the lungs, and Type IV in 50 per cent.

The various strains of pneumococci were identified by morphology, cultural reactions, inulin fermenting properties, bile solubility and, finally biologically with immune serums. Pneumococcus, Type IV, and allied green producing organisms were found to vary greatly both as regards bile solubility and inulin fermentation. Subsequent study of this heterogeneous group may extend it to include numerous strains of *Streptococcus viridans*. Hemolytic streptococci appear as late secondary invaders and were isolated from 43 percent of the lungs at necropsy. Staphylococci were frequently present.

### The Influenza Bacillus

It is evident that the influenza bacillus was isolated in only a relatively small percentage of the cases. Thus *B. influenzae* was present in four washed sputums—three times in predominating cultures growing typically as transparent minute colonies in symbiosis with staphylococci. It was recovered in one instance from the tracheal mucosa and three times from the lung cultures at necropsy. Influenza bacilli were never isolated from the lung punctures during life taken by preference from the early cases. On the other hand, the bacilli were recovered both in smears and in practically pure cultures from each lung in the case of a young soldier dying the fifth day of the disease. It appears that the Pfeiffer bacilli may have been the cause of the pneumonia in this case. In contrast to this single case we



have not been able to isolate the bacillus in any considerable percentage of the civilian patients either during life or from acute fulminating cases at necropsy. The early results indicate that the technic employed should have sufficed to recover the organism if it were present in any considerable number of patients.

Furthermore, the high percentage of pneumococci obtained during life and at necropsy and predominating in the sputum, tracheal mucosa and lung tissue both early and late in the course of the disease suggest that this organism is at least the most important secondary invader and is responsible for many of the rapidly fatal pneumonias. It may be that we are dealing with a highly virulent strain of pneumococci sufficient in themselves to produce a rapidly fatal lobular pneumonia.

### Experimental

Early in the course of our investigations we were impressed with the paucity of the bacteria in the nasopharynx at the onset of the disease and the marked degree of prostration exhibited in many of the patients. The possibility of a filtrable virus as the cause of the disease suggested the following experiments:

Experiment 1.—Oct. 2, 1918, the nose and throat of a patient having a typical case of influenza of forty-eight hours' duration was washed with 40 c.c. of sterile physiologic sodium chloride solution, and the collected washings were diluted to a total bulk of 60 c.c. and shaken for twenty minutes in a sterile bottle containing glass beads. The fluid was immediately filtered through two small tested Mandler filters of medium porosity. The clear Filtrate A was inoculated into the anterior nares of three volunteers in amounts varying from 0.5 to 1 c.c. in each nostril. One of the men thus inoculated complained of slight headache, and presented a moderate conjunctivitis and a temperature of 99 F. twenty-four hours after the inoculation. These symptoms rapidly disappeared, and no further symptoms developed in any of the three subjects.

Experiment 2.—Oct. 4, 1918, the nasopharyngeal washings in two typical cases of influenza were mixed together and agitated in a sterile bottle containing glass beads for a period of fifteen minutes. The first patient had been ill only ten hours while the second patient was in the fifth day of the disease. The mixture of washings was immediately passed through a Mandler filter as Filtrate A and a second smaller portion filtered through a small Berkefeld candle N as

Filtrate B. Filtrate A was inoculated into the anterior nares of two volunteers, and Filtrate B was similarly inoculated into the noses of two additional volunteers. One of the four subjects complained of a slight headache and presented himself twenty-four hours after the experiment with a definite coryza, conjunctivitis and lacrimation. These symptoms had completely disappeared by the following morning and the men had all remained well when seen two weeks later. Cultures of the clear filtrates were inoculated into glucose broth and in the anaerobic tissue ascitic fluid culture medium of Noguchi. All tubes remained sterile after the expiration of two weeks. From these observations, which confirm those recently reported by Keegan, it may be assumed that the etiologic agent is not filtrable.

Experiment 3.—Oct. 4, 1918, at 4 p.m., the trachea and main bronchi secured at necropsy from a patient dying on the fifth day of the disease was split parallel to its lumen and the swollen dark red mucosa curetted off and thoroughly ground up with sterile sand in a mortar to make a turbid suspension in 50 c.c. of sterile saline solution. The suspension was centrifuged at slow speed to throw down the gross particles, and half of the resulting red emulsion was passed through a Mandler diatomaceous earth candle of 12 pounds positive pressure. A *Macacus rhesus* monkey received 5 c.c. of the unfiltered suspension in each nostril, and 20 c.c. of the clear filtrate were injected at the same time very slowly intravenously. No symptoms developed.

Experiment 4.—Oct. 8, 1918, the monkey received 2 c.c. of the mixture of the nasopharyngeal washings in four early cases of influenza in each nostril after previous swabbing and washing out the protective mucus in the nares. No symptoms developed after seven days' observation.

### Complications and Sequelae

During the past five weeks of the present epidemic there were eighty-six pregnant women admitted to the obstetric wards of the hospital affected with influenza or pneumonia. Of this number twenty-one died shortly after miscarriage. Twenty additional deaths occurred before miscarriage could result, and forty-five patients recovered with or without miscarriage. The total maternal mortality has been 45.5 per cent.

Among other complications of the disease, eleven patients have developed a unilateral or bilateral purulent otitis media. Pure cultures of pneumococci were isolated from eight discharging ears, the hemolytic streptococcus in two pa-

tients and the *Streptococcus viridans* in the remaining case. One child developed an acute and fatal mastoiditis. Purulent frontal sinusitis was encountered in one instance at necropsy, and cultures yielded pure hemolytic streptococci. It is to be expected that sequelae of still more diverse nature may subsequently develop.

### Summary

A severe and rapidly spreading epidemic of influenza and bronchopneumonia first appeared at the Cook County Hospital, September 23. During the past five weeks more than 2,000 patients were admitted to the hospital. The disease is highly contagious, and the mortality among our patients has totaled 31 percent. The epidemic has seriously crippled the medical and more especially the nursing staff of the hospital. More than fifty of the nurses and twelve of the physicians have contracted the disease, three deaths occurring among the total number.

The influenza bacillus was isolated in only 8.7 per cent of the total cases and chiefly from a small number of soldiers. In one instance it appears that the influenza bacillus may have caused the fatal bronchopneumonia. Influenza bacilli were isolated only exceptionally from the civilian patients. Pneumococci were the predominating

organisms in the sputum, throat cultures and in the lung cultures both during life and at necropsy. Pneumococci of unusual virulence were the most important early secondary invaders, and have sufficed to cause many of the fatal pneumonias.

Experiments indicate that the disease is apparently not due to a filtrable virus.

In conclusion it is a pleasure to acknowledge our thanks to Dr. E. R. LeCount for supplying us with an unlimited amount of postmortem material and to Dr. D. J. Davis for his personal interest in the isolation and cultivation of the several strains of *B. influenzae*. ◀

### References

1. Quoted from Bacteriology of the "Spanish Influenza," *Lancet*, London, 1918, 2, 177.
2. Gotch, O. H., and Wittingham, H. E.: *Brit. Med. Jour.*, 1918, 2, 82.
3. Little, T. H.; Garofalo, C. J., and Williams, P. A.: *Lancet*, London, 1918, 2, 34.
4. Keegan, J. J.: "The Prevailing Pandemic of Influenza," *JAMA*, Sept. 28, 1918; p. 1051.
5. Park, W. H.: *New York Med. Jour.*, 1918, 108, 621.

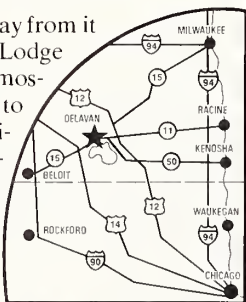
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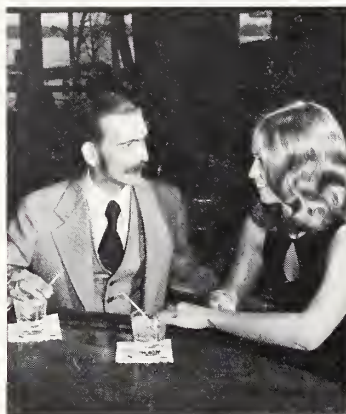
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## report

Illinois Society  
American Association of Medical Assistants

### 1977 Traveling Workshop

A workshop for Medical Assistants on MEDICARE - MEDICAID - MEDICHEK and CHAMPUS will be offered in various locations in the State of Illinois during the first two months of 1977. This traveling workshop is the result of the combined efforts of the American Association of Medical Assistants, Illinois Society, and the Illinois State Medical Society.

The workshops feature the carrier for Medicare (PART B-MEDICARE); Illinois Department of Public Aid (MEDICAID); Illinois Department of Public Health (MEDICHEK); and Civilian Health & Medical Program of the Uniformed Services (CHAMPUS). During the two and one-half hour sessions, the insurance and government experts will provide solutions to many problems that medical assistants encounter with the various programs. Recent changes in these programs, as well as tips for completing forms with relative speed and ease, are examples of the topics to be presented to participants.

Please make your reservations by completing the registration form below.

**CLARIFICATION:** The 87 persons listed in the November IMJ, who successfully completed the Medical Assistants examination administered this June, are certified by the Certifying Board of the American Association of Medical Assistants, rather than the State of Illinois, as formerly reported. The group of new CMA's, many of whom are AAMA members, is comprised of both students and working medical assistants.

### WORKSHOPS DATES AND LOCATIONS:

January 12, 1977 (Wednesday)

7:30-10:00 p.m.  
Mennonite Hospital  
807 N. Main St.  
Bloomington, IL

January 13, 1977 (Thursday)

1:30-4:00 p.m.  
Memorial Hospital  
4501 N. Park Drive  
Belleville, IL

January 19, 1977 (Wednesday)

7:30-10:00 p.m.  
Victory Memorial Hospital  
1324 N. Sheridan Road  
Waukegan, IL

January 20, 1977 (Thursday)

1:30-4:00 p.m.  
Illinois Valley Community Hospital  
LaSalle Division  
Route 351 South  
LaSalle, IL

February 9, 1977 (Wednesday)

1:30-4:00 p.m.  
Auditorium, Blue Shield Building  
233 N. Michigan Avenue  
Chicago, IL

February 16, 1977 (Wednesday)

1:30-4:00 p.m.  
Auditorium, Blue Shield Building  
233 N. Michigan Avenue  
Chicago, IL

### Registration Form—Government Workshops

Mail to: Mrs. Ruby Jackson, CMA, President, AAMA, Illinois Society  
333 West 76th Street, Chicago, IL 60620

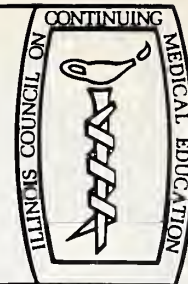
Name: \_\_\_\_\_ Workshop Desired: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip County

Phone: \_\_\_\_\_ AAMA Member? \_\_\_\_\_ If yes, Chapter \_\_\_\_\_  
Area code/number Yes/No

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## January, 1977

### Allergy

#### MANAGEMENT OF THE ADULT ASTHMATIC

For: Physicians. Lecture, January 12, noon, Christ Hospital, Oak Lawn. **Speaker:** Max Samter, M.D., Director, Institute of Allergy & Immunology, Grant Hospital. **CME Credit:** 1 hr. **AAFP Elective.** Fee: None. **Sponsor,** contact: Chicago Lung Association, 1440 W. Washington, Chicago, IL 60607. **Attn:** Milton A. Regier. **Telephone:** (312) 243-2000.

### Family Medicine

#### NEONATAL SURGICAL EMERGENCIES

For: Physicians. Lecture, January 18, 8:00 PM, Sherman Hospital, Elgin. **Speaker:** Dr. John G. Raffensperger, Dept. of Surgery, Children's Memorial Hospital. **CME Credit:** 2 hrs. **AMA Cat. 1.** Fee: None. **Sponsor,** contact: Continuing Medical Education Committee of Sherman Hospital, 934 Center Street, Elgin, IL 60120. **Attn:** Dr. Walter Gasser or Mrs. Mary Anne Stiegemeier. **Telephone:** (312) 742-9800 Ext. 649 or 769.

#### FAMILY PRACTICE REVIEW

For: Family Physicians. 5-day workshop and lectures. January 24-28, University of Michigan Medical Center, Ann Arbor, MI. **Speaker:** University of Michigan and Guest. **CME Credit:** 37½ hrs. **AMA Cat. 1:** AAFP Prescribed; AOA. Fee: \$250 (practicing physicians); \$125 (physicians in training). **Sponsor,** contact: Office of Continuing Education, Dept. of PGM/HPE, Towsley Center, University of Michigan Medical Center, Ann Arbor, MI 48109. **Attn:** Bette Armbruster. **Telephone:** (313) 763-0081. **Co-sponsor:** Michigan Academy of Family Physicians.

### Family Therapy

#### A DAY WITH MURRAY BOWEN

For: Physicians and Mental Health Professionals. One-day workshop. Friday, Jan. 21, 9:00 AM-4:30 PM. **Speaker:** Murray Bowen, M.D., Georgetown Univ. Hospital, Washington, D.C. **CME Credit:** 7 hrs. **AMA Cat. 1.** Fee: \$35.00. **Sponsor,** contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago 60611. **Attn:** Belinda M. Stone. **Telephone:** (312) 440-1414. **Co-sponsor:** Northwestern Memorial Hospital and Northwestern University Medical School.

### General Surgery Trauma

#### GENERAL SURGERY TRAUMA

For: All physicians. Clinical hospital program on General Surgery Trauma. January 18, 8 PM-10 PM. Cook County Hospital, Chicago. **Speakers:** To be announced. **CME Credit:** 2 hrs. **AMA Cat. 1:** AAFP Elective. Fee: None. **Sponsor,** contact: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. **Attn:** Mrs. Lillian Husa. **Telephone:** (312) 246-3788 or 482-8686.

### Internal Medicine

#### THE YEAR IN INTERNAL MEDICINE

For: All internists and family practitioners. Postgraduate course. January 19, 20 and 21 (9:00 AM-5:30 PM). Northwestern Memorial Hospital, Passavant Pavilion, Chicago. **CME Credit:** 21 hrs. **AMA Cat. 1:** AAFP prescribed. Fee: \$125. **Reg. Limit:** 110. **Sponsor:** Northwestern University Medical School and Northwestern Memorial Hospital. **Contact:** Jacob R. Suker, M.D., Associate Dean, Postgraduate Education, 303 E. Chicago Ave., Chicago, IL 60611. **Telephone:** (312) 649-7947.

## Psychiatry

#### PERIPATETIC QUEST FOR KNOWLEDGE

For: Professionals and Students in the Health Field. Lecture. Jan. 12, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. **Speaker:** Shervert Frazier, Jr., M.D., Harvard Univ. **CME Credit:** 2 hrs. **AMA Cat. 1.** Fee: \$15 prof., \$5 student. **Reg. Limit:** 100. **Reg. Deadline:** advance registration requested. **Sponsor,** contact: Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. **Attn:** Leo Jacobs, M.D. **Telephone:** (312) 827-8811.

#### SCHIZOPHRENIC COMMUNICATIONS

For: Mental health care professionals. Lecture. Jan. 19, 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker:** Gregory Bateson, Senior Lecturer, Kresge College Univ. of Cal. **CME Credit:** 3 hrs. **AMA Cat. 1.** Fee: \$10. **Reg. Limit:** 200. **Reg. Deadline:** Reservations (771-7000 ext. 342). **Sponsor,** contact: Riveredge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Attn:** John Pontarelli, Community Relations. **Telephone:** (312) 771-7000 ext. 305.

#### ETHICAL DISCIPLINE IN THE APA

For: Psychiatrists. Distinguished guest lecture series. Jan. 19, 8:00 PM. Offield Auditorium, Passavant Hospital, Chicago. **Speaker:** Robert A. Moore, M.D., Chairman, Comm. on Ethics, Amer. Psychiatric Assn. **CME Credit:** 1½ hrs. **AMA Cat. 1.** Fee: None. **Sponsor,** contact: Institute of Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago. **Attn:** Jeanne Smith. **Telephone:** (312) 649-8058.

## Radiography

#### QUALITY ASSURANCE EVALUATION OF THE RADIOGRAPHY DEPT.

For: Administrators or Radiologists. Lecture and Workshop. January 6, Cook County Graduate School of Medicine, Chicago. **Speaker:** Walid F. Hindo, M.D. (Coordinator). **CME Credit:** 24 hrs. **AMA Cat. 1.** Fee: \$125. **Reg. Limit:** 75. **Sponsor,** contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60607. **Attn:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### Recent CME Accreditations

The ISMS Committee on CME Accreditation has recently approved the CME programs of these institutions:

Elgin Mental Health Center  
Elgin

Illinois Society of Ophthalmology and Otolaryngology  
Danville

St. Francis Hospital and Medical Center  
Peoria

Tinley Park Mental Health Center  
Tinley Park

## February, 1977

### Emergency Medicine

#### EMERGENCY MEDICINE

For: Emergency physicians. 5-day workshop and lectures. February 21-25, University of Michigan Medical Center, Ann Arbor, MI. **CME Credit:** AMA Cat. 1: AAFP Elective; AOA. Fee: To be determined. **Sponsor,** contact: Office of Continuing Education, Dept. of PGM/HPE, Towsley Center, University of Michigan Medical Center, Ann Arbor, MI 48109. **Attn:** Bette Armbruster. **Telephone:** (313) 763-0081. **Co-sponsor:** Michigan Chapter, American College of Emergency Physicians.

### Musculoskeletal &

### General Surgery Trauma

#### MUSCULOSKELETAL & GENERAL SURGERY TRAUMA

For: All physicians. Clinical hospital program on Trauma. February 15, 8 PM-10 PM. Children's Memorial Hospital, Chicago. **Speakers:** To be announced. **CME Credit:** 2 hrs. **AMA Cat. 1:** AAFP Elective. Fee: None. **Sponsor,** contact: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. **Attn:** Mrs. Lillian Husa. **Telephone:** (312) 246-3788 or 482-8686.

### Pediatrics

#### SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY

For: Surgeons (Prep. for Board). Lecture. Feb. 14 (5 days). Cook County Graduate School of Medicine, Chicago. **Speaker:** John Raffensperger, M.D. (Coordinator). **CME Credit:** 38 hrs. **AMA Cat. 1.** Fee: \$200. **Reg. Limit:** 150. **Sponsor,** contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Attn:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### Psychiatry

#### MARRIAGE WITHOUT WALLS

For: Professionals and Students in the Health Field. Lecture. Feb. 2, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. **Speakers:** Samuel Janus, Ph.D., and Barbara Bess, M.D., both of New York Medical College. **CME Credit:** 2 hrs. **AMA Cat. 1.** Fee: \$15 prof.; \$5 students. **Reg. Limit:** 100. **Reg. Deadline:** advance registration requested. **Sponsor,** contact: Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. **Attn:** Leo Jacobs, M.D., Director of Medical Education. **Telephone:** (312) 827-8811.

#### THE MIND-BODY RELATIONSHIPS IN ILLNESS AND HEALING

For: Mental health care professionals. Lecture. Feb. 16, 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker:** Jerome D. Frank, M.D., Johns Hopkins U. School of Medicine, Baltimore. **CME Credit:** 3 hrs. **AMA Cat. 1.** Fee: \$10. **Reg. Limit:** 200. **Reg. Deadline:** Reservations 771-7000 ext. 305. **Sponsor,** contact: Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Attn:** John Pontarelli, Community Relations. **Telephone:** (312) 771-7000 ext. 305.

#### TECHNIQUES OF LEGISLATIVE INFLUENCE

For: Psychiatrists. Distinguished lecture series. Feb. 16, 8:00 PM Offield Auditorium, Passavant Hospital, Chicago. **Speaker:** Robert J. Campbell, M.D., Chairman, APA Commission on Legislation. **CME Credit:** 1½ hrs. **AMA Cat. 1.** Fee: None. **Sponsor:** Institute of Psychiatry-Northwestern University Medical School. **Contact:** Institute of Psychiatry, 320 E. Huron, Chicago, IL 60611. **Attn:** Jeanne Smith. **Telephone:** (312) 649-8058.



**REVIEW COURSE IN NEUROLOGICAL SURGERY**

For: Neurological Surgeons. Lecture. Feb. 4 (10 days).  
**Speaker:** Leonard I. Kratzler, M.D., (Coordinator).  
**CME Credit:** 95 hrs. AMA Cat. 1. **Fee:** \$400. **Reg. Limit:** 200. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**SPECIALTY REVIEW COURSE IN THORACIC SURGERY**

For: Surgeons. Lecture. Feb. 21 (5 days), Cook County Graduate School of Medicine, Chicago. **Speaker:** Constantine Tatoes, M.D., (Coordinator). **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** \$200. **Reg. Limit:** 200. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**MEDICINE FOR Today—****Winter Sessions**

**For:** Practicing physicians in all specialties. IAFP's 27th Annual Lecture Series, with A-v and Q&A supplement. Emphasis on Neurology, Dermatology, Oncology, & Cardiology. **CME Credit:** 30 hrs. AAFP Prescribed, AMA Category 1. **Fee:** \$100 AAFP mbrs., \$110 non-mbrs. Meets in these cities on dates noted:

*Belleville*—Feb. 17, 24, March 3, 10, 17, 24.

*Berwyn*—Feb. 16, 23, March 2, 9, 16, 23.

*Beverly*—Feb. 16, 23, March 2, 9, 16, 23.

*Centralia*—Feb. 16, March 2, 16.

*Champaign*—Feb. 17, March 3, 17.

*Chicago Nearwest*—Feb. 16, 23, March 2, 9, 16, 23.

*Chicago North*—Feb. 16, 23, March 2, 9, 16, 23.

*Chicago Southwest*—Feb. 16, 23, March 2, 9, 16, 23.

*Harvey*—Feb. 16, 23, March 2, 9, 16, 23.

*Hinsdale*—Feb. 23, March 9, 23.

*Melrose Park*—Feb. 16, 23, March 2, 9, 16, 23.

*Park Ridge*—Feb. 16, 23, March 2, 9, 16, 23.

*Peoria*—Feb. 17, March 3, 17.

*Rockford*—Feb. 24, March 10, 24.

*Rock Island*—Feb. 17, March 3, 17.

*Springfield*—Feb. 24, March 10.

For details of time and place, contact: Illinois Academy of Family Physicians, 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604. Telephone: (312) 427-5314.

### Have You Seen the New Illinois Mandatory CME Law?

In November, 1975, the Illinois Legislature passed a law requiring continuing medical education for re-licensure. The law will be administered by the State Department of Registration and Education. FREE copies of the law are available; write or call . . .

**Illinois Council/CME**  
 55 East Monroe St., Suite 3510  
 Chicago, IL 60603  
 (312) 236-6110

## Anesthesiology

**EKG FOR ANESTHESIOLOGISTS**

For: Anesthesiologists. Lecture and equipment demonstration. March 21 (for 5 days), Cook County Graduate School of Medicine, Chicago. **Speaker:** Alon P. Winnie, M.D., (Coordinator). **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** \$200. **Reg. Limit:** 35. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## Electrocardiography

**ADVANCED ELECTROCARDIOGRAPHY**

For: Internists, Cardiologists. Lecture. March 28 (for 2½ days). Cook County Graduate School of Medicine, Chicago. **Speaker:** Kenneth Rosen, M.D., (Coordinator). **CME Credit:** 17 hrs. AMA Cat. 1. **Fee:** \$125. **Reg. Limit:** 75. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**BASIC INTERNAL MEDICINE**

For: General or part-time specialty. Lecture. March 14 (for 5 days). Cook County Graduate School of Medicine, Chicago. **Speaker:** Sheldon S. Waldstein, M.D., (Coordinator). **CME Credit:** 40 hrs. AMA Cat. 1; AAFP Prescribed. **Fee:** \$200. **Reg. Limit:** 100. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## Family Medicine

## Family Medicine, Gynecology

**DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY**

For: Gynecologists, Family Practice physicians. Lecture. March 21 (for 5 days). Cook County Graduate School of Medicine, Chicago. **Speaker:** John G. Master-son, M.D., (Coordinator). **CME Credit:** 38 hrs. AMA Cat. 1; AAFP Prescribed. **Fee:** \$200. **Reg. Limit:** 100. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## Family Practice, Medicine

**BASIC ELECTROCARDIOGRAPHY**

For: Physicians interested in electrocardiographic interpretation. Lecture. March 21 (for 5 days). Cook County Graduate School of Medicine. **Speaker:** Kenneth Rosen, M.D., (Coordinator). **CME Credit:** 35 hrs. AMA Cat. 1; AAFP Prescribed. **Fee:** \$200. **Reg. Limit:** 45. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## Hematology

**HEMATOLOGY FOR MEDICAL TECHNOLOGISTS**

For: Medical Technologists. 5-day workshop. March 21-25. University of Michigan Medical Center, Ann Arbor, MI. **CME Credit:** CEU credit. **Fee:** to be determined. **Sponsor, contact:** Office of Continuing Education, Dept. of PGM/HPE, Towsley Center, University of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081. Co-sponsor: A.S.M.T.

## Musculoskeletal Trauma

**MUSCULOSKELETAL TRAUMA**

For: Physicians. Clinical hospital program on Trauma. March 15, 8 PM-10 PM. Highland Park Hospital. **Speakers:** To be announced. **CME Credit:** 2 hrs. AMA Cat. 1; AAFP Elective. **Fee:** None. **Sponsor, contact:** Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Husa. Telephone: (312) 246-3788 or 482-8686.

## Neurology

**REVIEW IN NEUROLOGY, PART I, BASIC**

For: Neurologists, Psychiatrists. Lecture. March 14 (for 5½ days). Cook County Graduate School of Medicine, Chicago. **Speaker:** Catherine Haberland, M.D., (Coordinator). **CME Credit:** 44 hrs. AMA Cat. 1. **Fee:** \$225. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**ADVANCES IN PEDIATRICS**

For: Pediatricians. 2-day lecture. March 2-3. University of Michigan Medical Center, Ann Arbor, MI. **CME Credit:** AMA Cat. 1, AAFP Elective; AOA. **Fee:** To be determined. **Sponsor, contact:** Office of Continuing Education, Dept. of PGM/HPE, Towsley Center, University of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081. Co-sponsor: American Academy of Pediatrics, Michigan Chapter.

## Psychiatry

**INSIDE-OUTSIDE: GETTING CLOSER**

For: Professionals and Students in the Health Field. Lecture. March 2, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. **Speaker:** Milton H. Miller, M.D., Professor and Head of the Dept. of Psychiatry, Univ. of British Columbia. **CME Credit:** 2 hrs. AMA Cat. 1. **Fee:** \$15 (prof.); \$5 (students). **Reg. Limit:** 100. **Reg. Deadline:** advance registration requested. **Sponsor, contact:** Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D., Director of Medical Educ. Telephone: (312) 827-8811.

**BIOENERGETICS**

For: Mental health care professionals. Lecture March 16, 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker:** Alexander Lowen, Ph.D., Bioenergetics authority, New York. **CME Credit:** 3 hrs. AMA Cat. 1. **Fee:** \$10. **Reg. Limit:** 200. **Reg. Deadline:** Reservations (771-7000 ext. 342). **Sponsor, contact:** Riveredge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations. Telephone: (312) 771-7000 ext. 305.

**QUALIFICATIONS FOR CLINICAL COMPETENCE****IN PSYCHIATRY**

For: Psychiatrists. Distinguished lecture series, March 16, 8:00 PM. Passavant Hospital, Chicago. **Speaker:** S. Mouchley Small, M.D., Professor and Chairman, Dept. of Psychiatry, State U. of New York at Buffalo. **CME Credit:** 1½ hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Institute of Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago, IL 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058.

## Surgery

**GENERAL SURGERY CONFERENCE**

For: General Surgeons. 2-day workshop. March 14-15. University of Michigan Medical Center, Ann Arbor, MI. **CME Credit:** AMA Cat. 1; AAFP Elective; AOA. **Fee:** To be determined. **Sponsor, contact:** Office of Continuing Education, Dept. of PGM/HPE, Towsley Center, University of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081.

**SPECIALTY REVIEW COURSE IN SURGERY, PART II**

For: Surgeons. Lecture. March 14 (for two weeks). Cook County Graduate School of Medicine, Chicago. **Speaker:** Robert J. Baker, M.D., (Coordinator). **CME Credit:** 99 hrs. AMA Cat. 1. **Fee:** \$400. **Reg. Limit:** 200. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**CME Planning Aids**

ICCME continually develops a variety of "how-to" material for CME Planners—DME's, program chairmen of hospitals and medical societies (both specialty and geographic), and others. All items are FREE to Illinois physicians and CME sponsors.

To learn what's currently available, request the "CME Planning Aids Order Form"; write or call . . .

**Illinois Council/CME**  
 55 E. Monroe St., Suite 3510  
 Chicago, IL 60603  
 (312) 236-6110

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARCOLA:** F.P. or G.P. needed to join only physician in true rural community (2,300 population). Must be willing to do O.B. Ultimate plans for new 3-man clinic. Close to beautiful county hospital less than 10 years old. Robert N. Arrol, M.D., 126 S. Locust, Arcola, Illinois, 61910. (217) 268-4444 or (217) 268-4404. (3)

**BLOOMINGTON:** Two active Internists seek Family Practitioners and Pediatricians to join evolving private group of primary-care practitioners. Group to consist of six physicians leasing office space in hospital-owned building. Organized within a Community Health Center setting. Contact: Michael Daniloff, Vice-President, Professional Services, Mennonite Hospital, 807 North Main Street, Bloomington, 61701 (309) 828-5241. (3)

**CAIRO:** F.P. and internist sought. Rural service area—20,000 population. Excellent salary. Fringe benefits including malpractice. Office and staff provided. Med staff privileges in 62 bed acute hospital with peds, OB/GYN, and surgery specialties. Excellent recreation—fishing, hunting, tennis, golf. Private and public schools. Jr., 4 yr. and Med schools nearby. Contact: N. Pettry, 2020 Cedar, Cairo. 618-734-2400. (1)

**CARBONDALE:** Family physician: innovative neighborhood health center in southern Illinois seeks Family Practice Physician to provide patient care and supervise other professionals, para-professionals in clinic setting. Salary negotiable. Position available October 1976. Write: Robert Stalls, Director of Human Resources, City of Carbondale, 602 E. College Street, Carbondale, Illinois 62901, (618) 549-5302. (2)

**CHAMPAIGN:** General Internist, Pulmonary Medicine, Allergist, Oncologist/Hematologist, Rheumatologist, Family Practitioner, Dermatologist, Neurologist, Urologist and ENT opportunities in 31-man multi-specialty, youth-oriented group. Guaranteed salary leading to early Associateship with future income based on individual productivity. Medium sized, Big-10 University community. Contact Mr. Arthur H. Perkins, Administrator, Christie Clinic, 104 West Clark Street, Champaign, 61820 (217) 351-1200. (3)

**CHICAGO:** Medical center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice. Contact: F. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625, 312-478-6000. (2)

**CHICAGO:** Physician needed for well established, ultra modern medical center. Full laboratory and X-ray. Congenial working conditions and excellent co-workers. Good hospital associations. No evenings or weekends. Clinic located south side, near lake. Contact, Mr. Lawrence, Booker Family Health Care Center, 747 E. 47th, Chicago, 60653. (312) 624-4800. (1)

**CHICAGO:** Staff Pathologist with a desire to develop new clinical laboratory procedures and work with an innovative specialized medical staff, needed to join our progressive university-affiliated Chicago hospital. Must be certified/eligible in clinical and anatomic pathology and interested in teaching. Excellent salary and benefit program. Write or call: Nancy Siegel, Staffing Specialist, Louis A. Weiss Memorial Hospital, 4646 North Marine Drive, Chicago, 60640, (312) 769-2162. (3)

**CLINTON:** Population 8500. Opening for solo general practice. Four physicians in General Practice at present. Twenty-five miles from Decatur and Bloomington. Office available. Recreational facilities excellent. Clinton Nuclear Power Plant under construction 6 mi. east of City. Contact: M. J. Hein, 422 West White, Clinton 61727, AC 217-935-3171. (2)

**COLLINSVILLE-EDWARDSVILLE:** Progressive towns, 15 miles from Downtown St. Louis. Ample recreational facilities, S.I.U. Campus nearby. New Community Hospital will open this summer. Need a qualified Ophthalmologist. No initial investment needed. Excellent opportunity for the future. Contact Mrs. Hall, 657 E. Broadway, East St. Louis 62205, (618-345-0417). (12)

**DANVILLE:** Need Primary Care Physicians. Also Neurologist(s) and/or Neurosurgeon(s). Population 43,000. Service Area 180,000. Excellent schools, near university. Contact R. V. Livengood, Lakeview Medical Center, Danville, 61832 (217) 443-5201. (3).

**HARVEY:** General Practitioner or Family Practitioner opening available in our practice. Practice in the Chicago area and in the south suburb. Good pay and benefits. Interested parties please contact 333-1411 or P.O. Box 677, Harvey, 60426. (3).



**ILLINOIS:** Variety of settings in agencies providing diagnostic, treatment, consultative and advisory services or administrative direction to medical programs. Completion of approved Medical school and 1 year internship/residency in approved hospital required. Must possess or acquire appropriate valid Illinois license before employment. Temporary certification not acceptable. Salary commensurate with skills and experience—Good benefits. Equal Opportunity Employer—Male or Female. Send resume to: Robert P. Gosnell, Manager, Counseling Services and Administrative Recruitment, Illinois Department of Personnel, 521 State Office Building, Springfield, Illinois 62706. (1)

**JUSTICE:** One or two good Family Practitioners needed: lovely new medical center (southwest), on-site surgery center, X-ray, laboratory, emergency room and pharmacy; complete staff 15 doctors for various specialties who are on staff at nearby 500 bed hospital. Opportunity for future partnership. Contact Dr. E. I. Breslar, Forest Hill Medical Center, 9050 W. 81st, Justice 60458. 312-594-3500. (2)

**McHENRY:** We have openings available for Board Certified or eligible OB-GYN, Pathologist and Orthopaedic physicians on the staff of our 23 physician multispecialty group. Incentive pay from day one with minimum guaranteed draw, malpractice paid, partnership after 1-2 years, excellent fringe benefits. We are 55 miles northwest of Chicago in the Chain-o-Lakes resort area. The medical group is physically adjacent to a 147 bed general community hospital and State Trauma Center. Jim Dickson, Personnel Director, McHenry Medical Group, McHenry 60050. (815 385-1050 ext. 332. (2)

**OLNEY:** ENT, Internal Medicine, Dermatology, Ophthalmology needed. 26 MD multispecialty partnership, 15,000+ referral population, new bldg., 1st yr. earnings guaranteed, 200 bed modern hospital, 4 wks. vacation, 2 wks. meeting per yr. Contact: David L. Potter, Adm., Weber Medical Clinic, 1200 N. East St., Olney 62450 (618) 395-4311. (2)

**ORLAND PARK:** Orland Park and far S.W. Chicago office, need general practice physicians, complete facilities both offices. New office bldg. completed Dec. 1, 1976. Contact: C. E. Cornelison, Adm., 10444 S. Kedzie, Chicago 60655, (312) 239-3000. (1)

**PINCKNEYVILLE:** Population 3500—Serves an area of 20,000. Medical group partnership of four physicians seeking fifth member. Complete office facilities—2 blocks from fully accredited hospital. Salary one year—then partnership. Good recreational facilities—near St. Louis. Contact: Clarence E. Cawvey, M.D., 206 North Main Street, Pinckneyville 62274 Phone: 618-357-2131. (2)

**ROCHELLE:** Population 10,000—Two primary care physicians needed. Hospital serves an area of approximately 20,000. Acute general 68-bed hospital with full services, including physical and respiratory therapies. Office space available adjacent to hospital. Located 25 miles from Rockford and a medical college, 17 miles from major university, and an hour-and-a-half from Chicago. Excellent schools, parks and civic organizations. Contact Administrator, Rochelle Community Hospital, 900 North 2nd Street, Rochelle 61068 (815) 562-2181. (2)

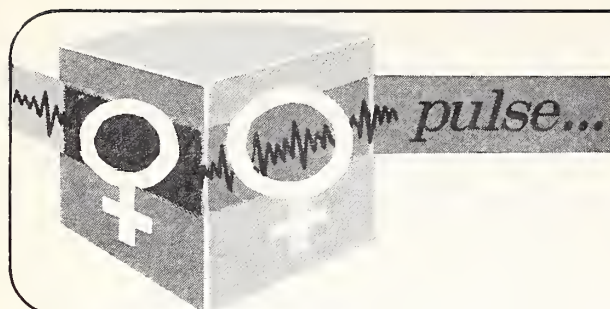
**ROCKFORD:** Opening for Board eligible Internist in multi-specialty group of Internists. Brand new building; two minutes from large, modern hospital. Near Rockford School of Medicine—part time teach opportunities if desired. Guaranteed income with full partnership after one year. 90 miles NW of Chicago on I-90. CONTACT: T. R. Glatter, M.D., 5670 E. State St., Rockford 61108. 815-398-4040 or 815-877-0096. (2)

**ROCK ISLAND:** Family practitioner, excellent guarantee and office arrangements. Send C.V. to Thomas J. Lavery, 2701-17th St., Rock Island, Illinois 61201 or call (309) 793-1000 (collect) for additional information. (1)

**SANDWICH:** General Practice Physicians. Substantial annual guarantee, plus office facilities. 50 miles west of Chicago. Additional physicians are needed due to recent illness of one physician and death of another. Modern 92 bed hospital. Contact: President, Sandwich Community Hospital, 11 E. Pleasant St., Sandwich, 60548 or Phone 815-786-8484. (3)

**SPRINGFIELD:** Emergency physician needed to supplement existing department in 650 bed community hospital with medical school affiliation. New emergency department facilities, 50,000 visits per year, excellent salary and fringe benefits, 40-44 hour week. Teaching position available if desired. Involvement with ongoing MERCI communications net and paramedic training program. Excellent opportunity to work, teach, and live in progressive midwest community with a metropolitan area of approximately 150,000. Contact E. W. Donelan, M.D., Chairman Emergency Services, St. John's Hospital, 800 East Carpenter, Springfield, 62702, 217-544-6464. (3).

**WAYNE CITY:** Thriving community located in Wayne County in southern-most Illinois. Office facilities furnished for young Family or General Practitioner. No physicians in this community. Contact: Grant Smith, President, First National Bank, Wayne City 62895; 618/895-2118. (2)



## of the doctor's wife

MRS. HAROLD KEEGAN, Editor

# Winnebago County Celebrates Silver Anniversary

For the past 25 years, a prime goal of the Winnebago County Medical Auxiliary has been to establish the auxiliary as a worthy asset to the Winnebago County Medical Society, the ISMS Auxiliary and its community. The physicians' wives have served as a catalyst organization in many areas of need and responsibility.

The establishment of the Rockford Nursing Foundation as a perpetual student nurse scholarship fund has made education possible for many nurses. From 1952-1976, \$46,528 has been raised by auxiliaries and put back into the community in the form of scholarships for students at the three hospitals and the junior college.



Mrs. David Norbeck, Winnebago County Medical Auxiliary president, cuts 25th anniversary celebration cake. Left to right: Mrs. Earl Klaren, 1st vice pres., ISMS Aux., Mrs. Johanna Lund, Winnebago County Medical Society executive administrator, Mrs. Norbeck and Mrs. John Ovitz, Jr., ISMS Auxiliary president.

The auxiliary has provided the Rockford School of Medicine with \$2,750 for student loans. Money for nursing scholarships and for medical student loans has been raised locally through the hard work of many auxiliaries.

During the early years of the formation of the Northern Illinois Blood Bank, auxiliary members did much of the footwork to secure blood donors. Fifteen hundred blood donors were procured in one year as a direct result of their work.

Thousands of bandages have been rolled and supplies collected by members for donation overseas. Over 10,000 hours were spent by physicians' wives during the last major outbreak of polio. Today, medical auxiliaries distribute immunization information and drive those children who need transportation to receive immunization.

Auxiliaries have worked for community health education through health fairs, and, in recent years, have also assisted the Winnebago County Medical Society with Community Health Week. Liaison members of the auxiliary have worked with special disease organizations for disease control.

Counseling and career information have been given to over 25,000 students in the past six years. Teams of auxiliaries have received state and national recognition. They have gone into the high schools with films and their own slide presentation to explain many of the 200 professions in the allied health field.

Volunteer work with the public health clinics is an ongoing program of the auxiliary. Both professional and clerical services are donated by the members. Services have also been given to the Children's Development Center in the pre-school testing program. Mental Health programs have been given many volunteer hours as well as donations.

The past presidents and membership were honored at a Silver Anniversary Luncheon on October 14. A letter of gratitude for the service of this organization was sent to the membership by Congressman John B. Anderson, a Proclama-





Mrs. Thomas Glatter, (left) and Mrs. John Leonard, chairman and co-chairman of the Silver Anniversary Celebration for Winnebago County Medical Auxiliary.

tion of Achievement was issued by the Mayor of Rockford, and the Winnebago County Medical Society presented their auxiliary with an engraved silver punch bowl. Mrs. Thomas Glatter, assisted by Mrs. John Leonard, chaired the event.

Special guests included: State-President Mrs. John Ovitz, President-Elect Mrs. Edward Szewczyk, Director Mrs. Eugene Vickery, 1st Vice-President Mrs. Earl Klaren, and County President Mrs. David Norbeck. State Chairmen in attendance were: Mrs. Selig Hodes, Mrs. Karl Reddies, Mrs. Elwood Kortemeier, Mrs. Don Hinderliter, Mrs. Wendell Roller, Executive Secretary Jane Swanson, and DeKalb County President Mrs. Russell Scott.

## SPECIAL NOTES

The ISMS Auxiliary Volunteer badges are now available as buttons. They may be ordered from Jane Swanson, executive secretary, 122 W. Boston Avenue, Monmouth, Illinois 61462. The charge of \$1.00 per badge will go to the Benevolence Fund.

The ISMS Auxiliary Winter Board Meeting will be held January 25, 1977, at the Holiday Inn Mart Plaza in Chicago.

## *The Privilege of Doing*

The doctor's wife of 1876—flocked with children and chores—had an expected life span of 35.5 years and little enough time for the work of her own family's survival. Today's spouse of 1976 can expect to live 71.0 years with an open option on what she/he will do. We have this legacy of more than 36 years. What use will we make of it?

I offer to you for the coming year a theme which comes from a statement by Dr. Albert Schweitzer: "It is not enough merely to exist, you must give some time to your fellow man, even if it is a little thing. Do something for those who need man's help—for which you get no other pay but the privilege of doing."

We do have the privilege of doing much to educate and inform ourselves so that we may make our own family's health better. There is much to be done in our communication to help our mates as they work for better health care. Let us be alert and aware of the needs waiting to be met with our particular talents and energies. We are limited only by our own imaginations. It does not take a large group of volunteers to meet every need. Just one warm human being who care for another is often the answer.

We can share ourselves—our compassion—our experience—and our time. Each one of us can find some activity which challenges us and makes the world a better place because of our participation. Let us hope that activity will be found in **MEDICAL AUXILIARY.**

Excerpted from Inaugural speech of Mrs. George Scofield, President—Alabama

Deluxe nine story medical building, adjacent to Columbus Hospital and Lincoln Park, has suites available for immediate occupancy. Inside parking & full cleaning services. Free moving expenses & two months free rent available

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## POSITIONS & PRACTICE OPPORTUNITIES

**PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT** and Emergency Room. Become part of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801. Phone (217) 337-3239.

**OB-GYN, ENT, PEDIATRICS, SPECIALISTS** needed by 16-man multispecialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., La Crosse Clinic, 212 South 11th Street, La Crosse, Wisconsin 54601.

**NEONATOLOGIST** to join 9 member Pediatrics Division of a 90 doctor multi-specialty clinic with adjacent hospital; located in Big 10 University community of 100,000; large referral practice, as well as primary care; new medical school offers opportunity for teaching; hospital has just under 1000 deliveries per year with 13,000 per year in area without designated center; OB/Pediatrics Departments are requesting state designation as perinatal center with completion in early 1977 of excellent new hospital, L & D, NICU facilities. Contact Medical Director, Carle Clinic, Urbana 61801.

**BOLINGBROOK**—population 30,000, drawing area 70,000. Growing at a rate of 4,000 people a year. Four M.D.'s established in the community. Urgent need for additional M.D.'s in all fields, particularly, OB and Peds. Associate or solo available. Send resume to: Manager, Bolingbrook Professional Building, 519 E. Briarcliff Road, Bolingbrook, Illinois 60439; (312) 739-5121.

**PEDIATRIC NEUROLOGIST** to join 9 member Pediatrics Division of a 90 doctor multispecialty clinic with adjacent hospital; located in Big 10 University community of 100,000; large referral practice, as well as primary care. New medical school offers opportunity for teaching; clinic has 3 member Neurology Department and active neurosurgical program, an EMI scanner and potential for limitless growth in neurosciences. Contact Medical Director, Carle Clinic, Urbana 61801.

**TWO FAMILY PHYSICIANS** with large hospital practice wish third associate who is Board Eligible, to join busy family practice. Located in Waterloo, Iowa, a northeast Iowa community of 75,000. All records dictated on the Problem Oriented Medical Records Systems. Ronald R. Roth, M.D. & Ronald D. Flory, M.D., 611 Black's Bldg., Waterloo, Iowa 50703.

**FAMILY PRACTICE POSITION** for one or two physicians. Satellite expansion to nearby smaller town in Southern Wisconsin provides excellent opportunity of enjoyable living. Administrative, retirement, technical and time-off coverage of a large group. No investment. Weekend coverage. Contact Frank C. Stiles, M.D., The Monroe Clinic, Monroe, Wis. 53566 or call (608) 328-7000.

**PHYSICIANS, SOUTHWEST MISSOURI.** Needed Immediately. Excellent opportunity, salary open for discussion. Call COLLECT 314-785-7701 ext. 61.

**ILLINOIS—EMERGENCY PHYSICIANS WANTED. EARN UP TO \$78,000** per annum in low volume or busy ER's. Work two days, off five, earn \$50-\$60,000. Work only 26 weeks, earn \$50-60,000. For further information write BOX NUMBER 871, IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**OBSTETRICIAN** to associate with OB-Gyn Department of established multispecialty group in St. Paul-Minneapolis and suburban areas. Excellent salary, generous fringe benefits. Tremendous growth potential in one of America's leading metropolitan areas. Curriculum vitae and references invited. Box 80100, St. Paul, Minnesota 55108.

**PSYCHIATRIST: STARTING SALARY \$35,000-\$45,000.** Prefer two years experience in Community Psychiatry. To carry treatment and supervisory responsibilities in a progressive and growing community mental health center. Medical staff includes two full-time psychiatrists and a complement of psychiatric consultants. A reasonable work pace and pleasant facilities. Enjoy with us the benefits of living and working in a scenic, rural community on the Ohio River, with the added advantage of being only 30 minutes from downtown Cincinnati, Ohio. Contact James F. Jones, Executive Director, Community Mental Health-Mental Retardation Center, Inc., 285 Bielby Road, Lawrenceburg, IN 47025. Equal Opportunity Employer.

**ASSOCIATE DIRECTOR FOR FAMILY PRACTICE RESIDENCY PROGRAM**—Newly-developed Family Practice Residency Program serving Waterloo-Cedar Falls area needs Associate Director to start February, 1977. Position involves teaching and supervision of Residents plus

direct patient care. New 7,000 sq. ft. model office. Program is affiliated with the University of Iowa College of Medicine and offers an opportunity for a more relaxed practice of medicine plus academic advantages. Adequate salary plus fringe benefits equal to 20% of base salary. Ample vacation and opportunity for postgraduate study. Contact: Charles A. Waterbury, M.D., Program Director, 635 Black's Building, Waterloo, Iowa 50703

**PRIMARY CARE PHYSICIANS WANTED** to locate in a new medical building adjacent to suburban hospital in midwest metropolitan area of 350,000 population. Guarantee offered. For additional details write or call collect Noel Lee, M.D., 4430-34th Avenue, Moline, IL 61265. Telephone: 309-797-5811 or 797-8119.

**INTERN OPENINGS—INTERNAL MEDICINE.** Due to recent expansion, first year openings in accredited, long-standing Internal Medicine training program in 511 bed hospital. Send inquiries to: Medical Education, Saint Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, Ill. 60657.

**PRIMARY CARE PHYSICIANS** for large university health service. Excellent facilities, good geographic location, good fringes. Illinois License required. Affirmative Action/Equal Opportunity Employer. Position open July, 1977. L. W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, Illinois 60115.

**INTERNIST** interested in new health care systems, preventive medicine, health education, patient care, as Chief of Clinical Medicine. Position open July 1977. Affirmative Action/Equal Opportunity Employer, L. W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, Illinois 60115.

## FOR SALE, LEASE OR RENT

**BUY OR RENT AN 800 SQ. FT. SUITE**, luxuriously finished and absolutely independent in a recently completed 13 Suite Professional Center in Barrington, Ill. A desirable place to practice and to live. Ample paved parking and just a few blocks from the recently approved 166 Bed Good Shepherd Hospital. Inquire now while the selection is good. Excellent terms. Write to Box 866, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago Ill. 60603.

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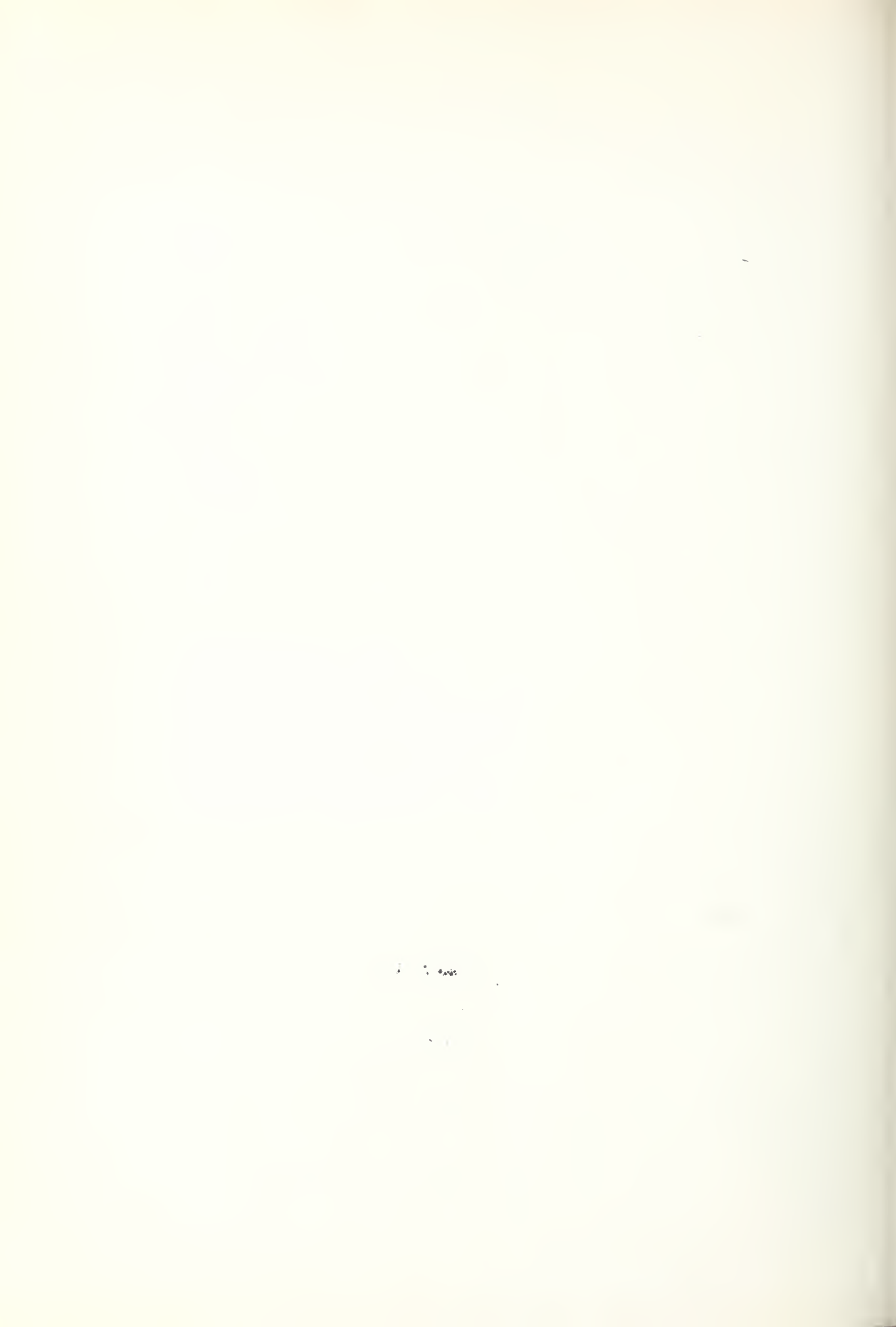














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